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Not just naloxone: Insights into emerging models to reduce drug harms

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A note on referencing:

Throughout the report references have been recorded as footnotes. When a specific program or intervention is profiled then the full reference is included in the text following the example.

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1. EXECUTIVE SUMMARY

Penington Institute has examined local and international approaches to reducing harm associated with drug use, allowing an assessment of what other approaches could be applied in Victoria. This report details Penington Institute's findings, particularly in relation to:

- practical strategies to respond to an overdose;
- the role of peer workers and peer-led models in harm reduction and related areas, such as behavioural health;
- evidence produced within the period 2000-2017; and
- only models and approaches that could be implemented within Victoria's existing legislative framework.

This report presents a range of models, interventions and approaches designed to reduce harms resulting from drug use (including overdose). It also offers findings from relevant research and evaluations. The report is divided into three sections:

1. ***Solutions that could strengthen Victoria's approach to harm reduction and improve outcomes for individuals***, including drug harm reduction and education programs, particularly those relating to overdose;
2. ***Emerging best practice in peer-led education and support***, including how peer-based harm reduction initiatives respond specifically to changing drug use consumption; and
3. ***Opportunities to improve integration and linkages*** across crucial sectors, such as health, education, justice and community services, with a view to improving responses for the most vulnerable and high-risk groups of people.

INFORMATION AND EDUCATION PROGRAMS - OVERDOSE PREVENTION INTERVENTIONS AND PRACTICAL STRATEGIES TO RESPOND TO AN OVERDOSE

This report gives attention to how best to share and deliver information about naloxone to individuals, families and others likely to witness an overdose. As outlined by WHO, a range of approaches need to be considered to further reduce the number of deaths from opioid overdose, including:

- monitoring opioid prescribing practices;
- curbing inappropriate opioid prescribing;
- curbing inappropriate over the counter sales of opioids;
- increasing the rate of treatment of opioid dependence;
- ensuring Opioid Maintenance Therapy is available and accessible;
- raising awareness about opioid overdose;
- linking those who are vulnerable to relevant services; and
- maximising the role of needle and syringe programs.

The report gives examples where broad coalitions are formed to create programs, training, strengthen pathways and provide accessible resources developed for different audiences and specifically for risk groups and people who have a higher chance of being in contact with someone at risk of experiencing an overdose. Examples of partnership/coalitions/collaborations include;

- OverdoseFreePA from Pennsylvania, (Page 38 and 92)
- Learn to Cope and NOMAD, (Page 57) and
- Project Lazarus (Page 61)

While studies show that educational and training interventions with the provision of take-home naloxone decrease overdose-related mortality, there is no one distribution model which stand out as preferable.

Take-home naloxone

Over the past five years, naloxone has dominated the overdose prevention literature. While administering naloxone will reduce the number of witnessed opioid overdoses, it is only one part of the intervention and does not address the underlying causes of opioid overdose.

One of the main challenges with naloxone is how best to achieve sufficient coverage of at-risk populations. The focus for naloxone distribution has moved from solely targeting people engaged in street-based opioid injecting who frequent services such as NSPs to include a range of key

populations and their interactions with different services/institutions. This expansion is in line with a 2014 WHO recommendation that all ‘people likely to witness an opioid overdose should have access to naloxone and be instructed in its administration...’ The provision of naloxone, with appropriate training, to people (including friends, family, and service providers) who use or come in contact with people who use opioids can lead to successful opioid overdose reversals. Based on the probability of witnessing an overdose, three target populations for take-home naloxone programs have been targeted across a range of initiatives and include:

- 1) People who use drugs, including: current opioid injectors; Heroin injectors upon release from prison; Former opioid users upon release from detox/rehab; and Individuals starting Opioid Maintenance Therapy.
- 2) Carers, including family members, friends and other close contacts of people who use drugs. Evidence shows that people in close contact with people who use drugs want training in overdose management and how to administer take-home naloxone.
- 3) Agency staff, including medical settings, healthcare providers and Needle and Syringe Programs. Evidence shows mixed level of support by agency staff in prescribing and administering naloxone.

Programs that stand out

- 1) The NTA overdose and naloxone training program for families and carers, National Treatment Agency for Substance Misuse (London, UK). (Page 56)
- 2) Learn to Cope and the NOMAD project, (Massachusetts, USA)
- 3) Naloxone program run through a residential treatment facility - Opioid dependent inpatients along with their family members received overdose prevention training. (Colorado, USA) (Page 60)
- 4) Project Lazarus (Wilkes County, Western North Carolina, USA)
- 5) OverdoseFreePA program. (Pennsylvania, USA) A collaboration between six organizations and 16 Pennsylvanian communities to increase community awareness and knowledge of overdose and prevention strategies, and support practices and initiatives.

PEERS, PEER-LED PROGRAMS AND HARM REDUCTION

There is no one definition or position of what, or who, a peer is. Many of the reviewed studies found that involving peers was a key factor for the success of a project or strategy: whether in terms of reducing risk behaviours; increasing community support for harm reduction efforts; increasing knowledge about overdose; or the success of harm reduction initiatives more generally. While much of the literature proceeds as if the effectiveness or benefits of peer-based strategies is a given, there have been notable attempts to demonstrate effectiveness.

There is breadth and diversity to the roles that peers can undertake within harm reduction programs. The distinct roles that peers fulfill in harm reduction settings include: harm reduction education; direct harm reduction and health services; peer support, counselling and referrals; research assistance; and advisory committees. (These are detailed in Figure 1, Page 68.)

The Exponents ARRIVE program (New York, USA) detailed in section three (page 70) is an example of a peer-based education program building participant's skills to reduce vulnerability and risks associated with drugs. This program was originally established to engage recently released prisoners with a history of injecting and in recent years broadened its scope to include other groups of people. The program is premised on the idea that offering a range of beneficial social services, even if they do not entirely relate to drug treatment, and supporting multiple visions of recovery, works better than using one rigid approach. A core element of the program is the ongoing engagement of each participant at multiple levels, including: psycho-education and health and wellness information with the primary purpose to teach self-management skills to address a range of health and social conditions. Enhancing participant's self-esteem is one important goal of the program.

Integrating peer-based strategies into harm reduction organisations

Primary NSPs in Victoria were originally managed and staffed by peers and although in recent years management is now variable with professionalisation, many of the staff are indeed peers although they often do not have that in their position title. They are however employed because of their close connection to the client population and personal lived experience.

One of the most productive topics addressed in the space of peer-based harm reduction is the integration of peer workers into harm reduction organisations. What has in many past initiatives been viewed as a 'cheap strategy' and therefore often underfunded is being increasingly perceived as integral to effective service provision. This is part of a much wider movement in public health policy wherein the experiences, knowledge and perspectives of people who use, or have used, are

valued and supported to work in health services to improve the service. Despite this growing recognition, a lack of peer integration into harm reduction services, with many stakeholders reporting that peer-based initiatives are often treated more like ‘add-on’ or ‘stand-alone’ programs, continues to be widely cited.

When attempting to evaluate the state of meaningful peer engagement across British Columbia’s harm reduction program, Greer and colleagues developed what they called a ‘peer engagement process evaluation framework’. This involved four key domains considered to be integral to achieving meaningful engagement of peers: 1) Supportive environment; 2) Equitable participation; 3) Capacity building and empowerment; and 4) Improved programming and policy. Helpful resources to consider further include:

- *A Peer Support Toolkit, developed by* Department of Behavioural Health and Intellectual Disability Services, Philadelphia in 2017. (Page 85)
- Guide to the competencies required of peer workers. (New Zealand). (Page 87)

Programs that stand out

The following examples provide insight into the value of peer involvement:

1. The Exponents’ ARRIVE program demonstrates the value of peers (people in recovery and those living with HIV) in leading this program in both design and delivery.
2. The drug alerts and communicating drug quality among peer networks research in British Columbia, Canada demonstrates the importance of involving peers in designing communications and providing opportunities for feedback to improve strategies for producing and disseminating information on local drug trends.
3. A speaker’s bureau provides a platform for people with lived experience of drug issues to share their stories, with the aim of raising awareness and reducing stigma.
4. The development of a *safer crack pipe kit* in Toronto, Canada provides a case study for how a local peer-run harm reduction program identified an emergent public health issue and successfully overcame various challenges to address it.

IMPROVING INTEGRATION AND LINKAGES

This section presents a range of models and interventions to improve responses for those who are vulnerable to harms associated with drugs, with attention to integration and linkages across the health, education, justice and community services system.

The criminal justice system is an important and under-utilised setting for implementing overdose prevention strategies. Numerous models have evolved through UK, USA and Australian programs.

Strengthening the distribution of naloxone is again presented in this section, by focusing on a range of different and challenging environments, including; post-release prison, emergency departments, pharmacies, and residential care and drug treatment centres. Examples include:

- Scottish National Take Home Naloxone program, whereby all 15 prisons in Scotland offer naloxone-on-release; (Page 100)
- the Prevention Point Pittsburgh, Pennsylvania based program provides outreach at homeless shelters, drug treatment programs and the County Jail, (Page 96) and
- Queensland’s case management intervention for post-released prisoners to support their broad health and social needs. (Page 97)

Programs that stand out

Most significant are the partnerships formed across a diverse range of professions and sectors.

- The Novas initiative in Ireland provides accommodation from people who are homeless and acknowledges that a multi-agency approach is best placed to provide the most effective impact in preventing and responding to the problem of overdose. (Page 104)
- Pennsylvania’s Overdose Task Force formed to break down information silos. A range of innovative programs have evolved from Pennsylvania’s coordinated partnership, such as the ‘warm hands’ initiative in emergency departments, whereby contact with a recovery expert commences within the hospital ensuring a ‘proper recovery plan’ is made prior to discharge. (Page 92)
- The value of partnerships is also apparent in a Pittsburgh hospital whereby pharmacists work with physicians and social workers to develop an outreach program to increase naloxone prescribing. (Page 108)

WHERE TO FROM HERE

Overdose is a complex and multifaceted issue requiring a comprehensive response from all levels of government and a diverse range of organisations beyond the health sector. The challenge for Victoria, in building an effective and compassionate response to reducing harms associated with drugs and reducing the incidence of overdose across different settings, is to decide what to invest in, who to involve and how best to execute that investment.

Many of the examples in this report highlight achievements gained through partnerships between governments, agencies, healthcare providers, frontline workers, communities and people who use drugs. Many major and successful responses to rising overdose rates have been developed in response to a crisis. Project Lazarus in North Carolina and Pennsylvania's work in forming a comprehensive coalition and broad platform were formed in response to a crisis felt throughout the community.

The following offers some insights in how to proceed to build a comprehensive and compassionate response.

Building partnerships

A common thread throughout the report's three sections addressing; 1) information and education programs, 2) peers, and 3) improving integration and linkages, is that health, education, justice, human services and communities all play an important role in preventing harms associated with drug use. The challenges are significant and no organisation or government department working alone can solve these problems. The measured benefits gained from these partnerships are obvious and easily justified.

Opportunities exist for relevant agencies, government departments, and key individuals including peers, to work together. There are various examples of small effective partnerships. These partnerships, which can be simply formed within traditional sectors (for example; between social workers, outreach workers, doctors and pharmacists) or across sectors, need to be encouraged and supported. The need to respond strongly across primary, secondary and tertiary health settings, as well as through human services and in localised areas, makes intergovernmental collaboration essential. The US is tackling overdose with increasing collaboration between federal and state governments.

Pennsylvania's Overdose Prevention Coalition is one example of a complex and high profile partnership. The goal of the collaboration is to increase community awareness and knowledge of overdose and overdose prevention strategies, as well supporting practices and initiatives that will

decrease drug overdoses and deaths in the communities. The initial goal of the Pennsylvania Overdose Task Force was to develop a rapid response mechanism to break down information silos so that law enforcement and emergency medical services could have real-time trends information readily available to them. The Task Force has also built and promoted a shared online platform to help facilitate timely sharing of critical information. Finding and supporting ways to enhance sharing of critical information, to encourage smart use of data and linkage of that data, is vital in identifying people in need and offering the right support at the most appropriate time.

The role of peers

Examples offered in this report tell of the diversity and value of peer workers and how it is important not to limit the response to overdose to one type of peer. A central message is that there is no one definition describing what makes a peer nor is there one type of activity. There is breadth and diversity to the roles that peers take on within harm reduction programs and other services relating to drug use and treatment. The wide and complex spectrum that peers operate in, as demonstrated by the examples in this report, needs to be acknowledged and encouraged.

The literature demonstrates that there has been a shift in how peers are understood and valued, which is documented beyond the AOD space; most notably in the behavioural and mental health space. However, a lack of peer integration into harm reduction services continues to be widely cited.

Encouraging the integration of peer workers into harm reduction organisations is showing to be a valuable investment and integral to effective service provision. Example of peer engagement frameworks exist to assist organisations in achieving meaningful engagement of peers and to ensure peers are not treated as ‘token’. Engaging peers requires commitment and investment by organisations. They provide a valuable resource in networking, outreach throughout the community and importantly ‘inreach’ within the organisation to help engage relevant sections and individuals of an organisation to provide necessary service and support to clients.

A key aim of the section on ‘peers, peer-led programs and harm reduction’ is to outline ways that peer integration can be strengthened and developed, as well as the benefits of doing so and the kinds of challenges that are typically experienced. The literature shows growing support for broadening the scope of peer work to include low commitment, easy to engage with roles alongside more complex roles with greater levels of responsibility. Doing so caters for different individual needs, goals, capacities, and life situations.

Helping people transition from prison back into the community

There are many examples, from various countries, documenting the value of supporting people prior and upon release from prison. Interventions in the immediate post-release period present valuable opportunities to reduce harms, including overdose. Prison through-care programs support prisoners via a range of interventions that can improve someone's health, provide a range of social support and ultimately reduce risk of death. These include:

- pre-release education on overdose risks and prevention;
- continuation and initiation of substitution treatment and;
- improved referral to aftercare and community treatment services.

Pre-release education also includes supporting ways to get naloxone into the hands of people as soon as they leave prison. Scotland provides an example where take-home naloxone is distributed in the community as well as in prisons for prisoners upon release.

Prison through care, which involves improving a range of services between prison and community, is also critical in this response. Again, Scotland's work stands out in this area. In addition, the recent Queensland-based trial for a case management intervention for adult prisoners/ex-prisoners is also an example acknowledging the potential rewards of this area. Evidence shows that brief and low-intensity interventions can have a significant and sustained impact on healthcare usage for ex-prisoners.

Naloxone

Australia's present access arrangements for naloxone have enabled some effective and innovative models of distribution, especially where highly motivated practitioners – 'champions' of overdose prevention within both their organisations and communities – have established coordinated arrangements with local pharmacists and doctors. However, these models are bespoke, highly reliant on individual actors and generally not scalable.

Convenient and affordable naloxone access needs to be a given; it ought to simply 'work.' It is telling that countries that have scaled up the use of naloxone in community settings do not make it so difficult to get it into people's hands. By contrast (given naloxone is a high-efficacy, low-risk medicine), Australia's current arrangements for prescribing and dispensing naloxone are unduly complex and restrictive. Asking overdose prevention workers to continuously correct for this complexity is not an efficient use of their time. They would be better deployed deepening their engagement with people at risk of overdose and widening their engagement with key groups of overdose witnesses (such as friends and family). Simplifying naloxone access will facilitate this – and,

at the same time, it will give workers a better, cheaper and more convenient naloxone service to 'sell' to their clients. A further improvement would be a greater diversity of naloxone products, including intranasal naloxone, in Australia's market – thus providing choice to consumers.

- Naloxone needs to be free for those who need it.
- Naloxone must be easily available.
- Naloxone distribution cannot rely on the few 'champions'.

Enhancing opportunities to address the underlying causes of opioid overdose

Over the past five years, naloxone has dominated the overdose prevention literature and has been a major focus in policy and service delivery. While administering naloxone will reduce the number of witnessed opioid overdoses, it does not address the underlying causes of opioid overdose.

Addressing a range of social and health needs of those who are marginalised and vulnerable underpins some of the more comprehensive and successful programs detailed in this report. There is a role for programs to engage people at risk of overdose that operate in a range of settings beyond healthcare services (housing, mental health, residential treatment services, post-release from prison, OMT and NSPs). Most notably, the connection between diagnosed mental illness and clinically documented drug dependence is well documented. The Victorian Coroner's Office states that many people who have fatally overdosed were known to the health system for many years.

Providing support and training in life skills and ongoing engagement with people at risk at multiple levels, including: psycho-education and health and wellness information, with the primary purpose to teach self-management skills to address a range of health and social conditions, will have a significant impact on reducing harms associated with drugs.

Strengthening communities to respond to signs of overdose risks

A universal theme in reducing rising level of overdose is the need to raise community awareness of the signs and risks of overdose and to provide practical information and advice to help people reduce their risk of overdose. For communities to be safe, healthy and ultimately support people who use drugs and their families, they must be given resources and supported in developing a local response. Communities need to know what is happening and be able to respond or intervene early before drug use becomes a problem.

Misinformation about overdose and the role of underlying causes need to be addressed through a range of mediums. Raising awareness needs to happen on a large and broad scale that supports a national conversation which is embedded within communities. Community-based speaker bureaus play an important part in bringing people together, raising awareness and reducing stigma.

This report highlights that resources need to be provided to bring people and communities together to support and facilitate service delivery. Raising general community awareness and providing practical information and advice to help people reduce their risk of overdose is built into some of the examples presented in this report. The examples demonstrate the value of engaging family, friends and peers of people at risk of overdose to assist them in playing an important role in preventing an overdose outcome.

Continuing to invest in existing harm reduction programs

- Opioid Maintenance Therapy

Ensuring Opioid Maintenance Therapy is accessible and affordable is an important strategy to help control prescription opioid misuse as well as heroin addiction and overdose. Opioid Maintenance Therapy is an essential medicine that can significantly improve and save lives. People who inject drugs and are not receiving OMT are less likely to be engaged with the broader health system, are likely to be harder to reach to provide support with fewer opportunities to deliver appropriate additional harm reduction practices.

- Needle and syringe programs

Needle and syringe programs (NSPs) continue to be one of the most successful and cost-beneficial public health investments in Australia's history. The core responsibilities include:

- preventing the transmission of blood borne viruses by dispensing sterile injecting equipment; and
- encouraging safer injecting practices.

At their best, NSPs also connect their clients with the support they need – including drug treatment, mental health and housing services. NSPs represent a unique opportunity to address the complex interactions of drug use, poor mental and physical health, socioeconomic exclusion and crime. NSPs are often the only regular service touchpoint for their clients and offer an ideal environment to support peer-based 'outreach' and 'inreach' work.

Significant population growth has heightened insufficient coverage of NSPs, particularly in outer metropolitan Melbourne fringe areas, placing greater pressure on secondary NSPs, which are not designed to operate to the level of primary NSPs. These same communities also experience high rates of disadvantage. Demand for mental health services in growth areas have far outstripped projections – a situation driven primarily by escalating harms related to crystal methamphetamine. NSPs have a role to play in this response. Inadequate access to NSPs is not just a problem for the health of the community; it creates missed opportunities to engage

people who are at high risk of drug dependence and crime and ultimately engaging with people at risk of overdose.

2. INTRODUCTION AND BACKGROUND

INTRODUCTION:

In November 2016 Pennington Institute was commissioned by the Victorian Department of Health and Human Services to examine and report on local and international approaches to reducing harm associated with drug use, allowing an assessment of what other approaches could be applied in Victoria.

In particular, the report was to consider:

- practical strategies to respond to an overdose;
- the role of peer workers and peer-led models in harm reduction and related areas, such as behavioural health;
- evidence produced within the time period 2000-2017; and
- only models and approaches that could be implemented within Victoria's existing legislative framework.

This report presents a range of models, interventions and approaches designed to reduce harms resulting from drug use (including overdose). It also offers findings from relevant research and evaluations. The report is divided into three sections:

1. **Solutions that could strengthen Victoria's approach to harm reduction and improve outcomes for individuals**, including drug harm reduction and education programs, particularly those relating to overdose;
2. **Emerging best practice in peer-led education and support**, including how peer-based harm reduction initiatives respond specifically to changing drug use consumption; and
3. **Opportunities to improve integration and linkages** across crucial sectors, such as health, education, justice and community services, with a view to improving responses for the most vulnerable and high-risk cohorts.

While every effort was made to examine a diversity of evidence, it was not possible to address every aspect of Victoria's drug use landscape. Most, though not all, examples in this report relate to injecting drug use. In line with the requested scope of this review, some approaches to harm reduction, such as supervised consumption, were not included.

Nevertheless, by presenting a wide range of models, elements of models and strategies, we trust the report will support individuals and organisations to develop their own innovative models of harm reduction.

BACKGROUND:

Overdose often happens accidentally, with people overdosing on many substances, including alcohol, benzodiazepines, opioids, stimulant drugs or more commonly a mixture of drugs. Contrary to stereotypes about the age of people who die of accidental overdose, Australians aged 40-49 are the most likely to die of a drug overdose. In recent years, there has also been a large increase in overdose deaths in rural and regional areas, which has been driving the overall increase. Over the period 2008-2014 there was an 87 per cent increase in prescription opioid deaths in Australia, with the greatest increase occurring in rural and regional Australia which saw a 148 per cent increase.¹

As highlighted by the Victorian State Coroner's submission to the Inquiry into Drug Law Reform, March 2017, there has been an upwards trend in number of overdose deaths in Victoria between 2009 and 2016, with approximately 70 per cent of deaths caused by multiple contributing drugs rather than a single drug. Pharmaceutical drugs contributed to approximately 80 per cent of Victorian overdose deaths each year. The proportion of overdose deaths involving illegal drugs was approximately 40 per cent annually between 2009 and 2014, increasing to 50 per cent in 2015 and 54 per cent in 2016. Benzodiazepines were the most frequent contributing pharmaceutical drug to fatal overdoses in Victoria, followed by opioids then antidepressants. The overall five most frequent contributing individual drugs to Victorian overdose deaths between 2009 and 2016 were (in descending order) diazepam, heroin, alcohol, codeine and methadone.²

The submission highlighted the presence of overlapping diagnosed mental illness and drug dependence among suicide and fatal overdoses. A study undertaken by Turning Point in collaboration with the Coroners' Court of Victoria examined the circumstances in which pharmaceutical drugs were involved in overdose deaths in Victoria. The results from 838 overdose deaths between 2011 and 2013 in Victoria shows that 49.6 per cent of the study cohort had both a diagnosed mental illness and clinically documented drug dependence. It is also clear from the data that many had a long established clinical history of mental illness and drug dependence. The submission highlights an important issue:

¹Penington Institute, Australia's Annual Overdose Report 2016

²Victorian State Coroner's report to the Inquiry into Drug Law Reform, March 2017, p. 28.

...these deceased were known to the health system, and had in most cases been known to the health system for extended periods of time - greater than 10 years.³

Harm Reduction - Definition

Harm Reduction International offers the following definition:

‘Harm Reduction’ refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community.⁴

Ageing population - Injecting practices in Victoria:

Data from the IDRS (Illicit Drug Reporting System) and ANSPS (Australian Needle and Syringe Program Survey) conducted by Kirby Institute note that while heroin continues to be the most commonly reported drug of injecting, this population is ageing. With such an ageing population there are numerous comorbidities, including many ageing heroin users in Victoria living with a disability and other chronic health conditions, poverty, unemployment and periods of incarceration. With these condition comes the increased risk of overdose.⁵

Changing drug use consumption:

In recent years, methamphetamine use has emerged as a major issue throughout many communities in Victoria.⁶ Along with increased level of use, the patterns of methamphetamine use have changed with increased injecting. The 2013 National Drug Strategy Household Survey (NDSHS) reports a shift from the use of methamphetamine in powder form (speed) to crystal methamphetamine (ice). In Victoria in 2010, 72 per cent of people who used methamphetamine in the previous 12 months used powder with only 10 per cent using crystal. In 2013, this changed significantly, with 47 per cent of people using mainly powder and 44 per cent of people using mainly crystal or ‘ice’, and using it more

³ Ibid, p. 45.

⁴ Harm Reduction International, <https://www.hri.global/what-is-harm-reduction>

⁵ Cogger, S., Dietze, P., & Lloyd, B. (2014). Victorian Drug Trends 2013: Findings from the Illicit Drug Reporting System (IDRS) *Australian Drug Trends Series No. 112*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

⁶ Westmore, T., Van Vught, J., Thomson, N., et al. (2014). Impacts of Methamphetamine in Victoria: A Community Assessment. Melbourne: Penington Institute.

frequently.⁷ Increase in methamphetamine-related harms has seen more than a 250 per cent increase in the number of fatal overdoses involving methamphetamine since 2010 (Coroners Court of Victoria, 2014). Methamphetamine is now second to heroin as an illicit drug contributing to overdose deaths in Victoria.⁸

There have been significant changes in illicit drug markets in Australia since the introduction of Needle and Syringe Programs (NSPs) in 1985.⁹ Despite these shifts, how NSPs operate and how they are funded has not changed. While demand for heroin has remained, injection of drugs such as methamphetamine has become more common, as has poly-drug use. More recent changes in drug use include increasing use of drugs such as pharmaceuticals, performance and image enhancing drugs (PIEDS) and new psychoactive substances (NPS).¹⁰ Other significant changes in drug consumption in recent years has been the use of technology, including the internet and social media, in both buying and selling drugs, communicating about drug use and as a source of information about drugs.¹¹

The misuse of pharmaceuticals continues to be a significant problem in Australia. According to the most recent *Australian NSP Survey National Data Report (2015)*, pharmaceuticals are the third most injected substances in Australia. It is not uncommon for people who inject heroin to also inject methamphetamine (ice) and pharmaceuticals (IDRS).¹² It would appear that increases in the availability of both opioids and common benzodiazepines have coincided with an increase in their misuse. In the 2013 Victorian IDRS, 22 per cent of the sample had injected oxycodone and 19 per cent had injected morphine in the past six months.¹³ Almost half (47 per cent) of IDRS sentinel informants cite substitution for heroin as a reason for using pharmaceutical opioids. Almost a third (31 per cent) mention use of pharmaceuticals for preventing withdrawal. Access to

⁷ Australian Institute of Health and Welfare, (2014) National Drug Strategy Household Survey: Detailed Report 2013 Drug Statistics Series No. 28. Canberra: AIHW

⁸ Westmore, T., *op cit*, p.7.

⁹ Horyniak, D., Stoové, M., Degenhardt, L., Aitken, C., Kerr, T., & Dietze, P. (2015). How do drug market changes affect characteristics of injecting initiation and subsequent patterns of drug use? Findings from a cohort of regular heroin and methamphetamine injectors in Melbourne, Australia. *International Journal of Drug Policy*, 26(1), 43-50.

¹⁰ Iverson, J., & Maher, L. (2013) *Australian NSP Survey National Data Report 2008-2012; Prevalence of HIV, HCV and injecting and sexual behaviour among NSP attendees*. Sydney: The Kirby Institute for Infection and Immunity in Society, University of New South Wales.

¹¹ Barratt, M., & Lenton, S. (2013). Drugs and the internet. In A. Ritter, T. King & M. Hamilton (Eds.), *Drug Use in Australian Society* (pp. 272-293). Melbourne: Oxford University Press.

¹² Iverson & Maher, *op cit*.

¹³ Cogger, S., Dietze, P., & Lloyd, B. (2014). Victorian Drug Trends 2013: Findings from the Illicit Drug Reporting System (IDRS) *Australian Drug Trends Series No. 112*. Sydney: National Drug and Alcohol Research Centre, University of New South Wales.

pharmacotherapy continues to be a critical harm reduction response and increasingly so in addressing pharmaceutical opioid misuse among injecting drug users.¹⁴

It is well documented that the needs of people who inject drugs are complex. Injecting related injury and disease is a concern for many people who inject, ranging from non-serious to life-threatening harms. Marginalization and vulnerability experienced by people who inject drugs is not uncommon along with experiencing a range of chronic physical and mental health issues. This very diverse population even when in contact with a Needle and Syringe Program experience harms from injecting.

CURRENT SERVICES OPERATING IN VICTORIA:

The Victorian Government supports a range of services designed to reduce harms resulting from drug use including overdose. The following outlines some of these:

Needle and Syringe Programs:

The importance of Needle and Syringe Programs as a public health strategy is well documented and acknowledged in the recently expired National NSP Strategic Framework 2010-2014, which notes that:

In Australia, the Program (NSP) is the single most important and cost-effective strategy in reducing drug-related harms among IDUs [injecting drug users].¹⁵

NSPs are invaluable, trusted and often singular service touchpoints for a very diverse client base. Needle and Syringe Programs provide sterile injecting equipment, health information and education and voluntary referral to health and welfare services for people who use drugs. The service is unique as a preventative and early intervention measure, located between supply reduction (such as policing) and demand reduction (such as abstinence campaigns and encouragement into treatment).

Since NSPs began in the mid-1980s, the program has developed in response to the range of difficulties faced by people who inject drugs. Building on the need for sterile equipment, it has become a central hub and gateway for many clients to access a range of services and interventions. Importantly the role of NSPs extends beyond reducing the Blood-Borne Viruses (BBVs) in the

¹⁴Degenhardt, Gilmour, Shand, Bruno, Campbell et al., (2013) Estimating the proportion of opioids that is consumed by people who inject drugs in Australia Drug Alcohol Rev. Sep; 32 (5): 468-74. p.30.

¹⁵ National NSP Strategic Framework 2010-2014, p. 14

community and addressing harms associated with drug use into broader healthcare. Apart from exposure to BBVs, people who inject drugs can also suffer from vein injury leading to cellulitis and septicaemia, mental health problems, Sexually Transmissible Infections and overdose.

NSPs reach more people who inject drugs than any other service. There are approximately 3500 Needle and Syringe (NSP) services in Australia that provided 49.4 million clean needles and syringes from an estimated 755,000 occasions of service in 2015/16 (Kirby Institute 2016 National Data Report: Needle and Syringe Program National Minimum Data Collection). This is an extraordinarily large network of front line health services waiting to be better utilised. On a snapshot day in 2016, around one in ten interactions with a client at an NSP involved a referral. With investment, NSPs can increase health referrals and provide person-centred support for people who inject drugs to treat hepatitis C. NSPs are often the only interface between people who use drugs and healthcare services and are therefore uniquely placed to address the full range of needs experienced by people who inject drugs (PWID). The service provided by NSPs also indirectly benefit families of people who inject and the broader community.

With the many benefits offered by NSPs, the program faces a range of constraints that undermine systematic fulfilment of its aims and objectives, including highly variable hours which are often insufficient to meet client demand. Physical set-up can compromise discretion and curtail client access to the full range of services. Equipment and service provision, the supply of education and information, the frequency of general and targeted health campaigns, and the range and techniques of referral, all vary with outlet type and location.

All NSP outlets provide services from a fixed-site service or utilise a mobile/outreach model. There is however a broad diversity in service delivery models from services being provided from the main reception of a generalist health service, from a separate room within the host organisation, to self-service models where clients access packs of needle and syringes from a cupboard within a health service. These latter models have limited capacity to provide ancillary interventions such as health education and referrals to other health and welfare services.

There are two main types of NSPs – the Primary NSPs whose main business is to provide the service and have dedicated NSP workers that are fully funded, compared to Secondary NSPs which are co-located in a range of services and most commonly within community health services and hospitals.

There are 20 primary NSPs in Victoria, which tend to be located in more populous areas and in areas with active street drug markets or high rates of injecting drug use. Only primaries received funding

to staff and operate their NSP; consequently, they provide a more sophisticated level of service for their clients. Primary NSPs dispense about 53 per cent of injecting equipment in Victoria.

Secondary NSPs, although they dispense 41 per cent of sterile injecting equipment, are not funded by government (except to cover the cost of equipment dispensed). Secondary NSPs provide equipment as an adjunct to their main functions; they are often located in community health centres, hospital emergency departments, and drug treatment and youth agencies. A small number of secondaries are funded to operate a mobile/outreach NSP service or to employ a harm reduction worker.

In Victoria, NSPs can be found in almost all towns and cities across the state. There is real potential to support secondary NSPs to be able to engage clients in health promotion and address a range of drug use related harms.

Given the disparities in funding, there is diversity in the services that are available through NSP outlets in Victoria:

- distribute free sterile injecting equipment;
- provide facilities for equipment disposal;
- provide clients with harm reduction information;
- provide clients with information on other health and welfare issues;
- provide referrals to other health and welfare services to clients; and
- engage in community education/liaison.

Some (and particularly the primary outlets) provide nursing interventions for a range of health concerns, overdose prevention and response, a drop-in space with access to the internet, support and food services. Some offer regular barbecues or breakfast for clients.

Penington Institute is funded by the State Government as the peak body for harm reduction. This includes workforce development services for the Victorian Needle and Syringe Program. This comprises:

- training people who work in frontline services to understand drugs and drug users, engage clients, establish trust, provide harm reduction advice and interventions and link clients to the services they need;
- providing networking and development opportunities for the NSP sector;
- maintaining, and supporting others to maintain, community acceptance of NSP services; and

- leading strategic and problem-solving initiatives in relation to NSP policy.

NSP staff and lived or 'past-experience' with drug use:

Needle and Syringe Programs, both primary and secondary programs, vary in how and where they operate. The following quotes from NSP workers, who were consulted for this review, reflect on the question of where are 'peers' in their service? While the programs are not peer run, staff with drug use experience is usually considered an asset while often not formally acknowledged.

We employ people with lived or with a 'past-experience'. While it's not critical it is highly valued. They are not called 'peer workers' because they are more than that and they are not employed because of that. (Community based NSP, Coordinator)

Most of the work in this sector is ideologically driven. I believe there is a place for peer outreach in partnership with professional outreach where lived experience is desirable but not the main factor. We have staff here whose experience with drug use is noticeably evident – perhaps too evident. We also have people working here who have a lived experience of drug use, but it is not at the forefront of what they do or how they present. It informs their work. It is the respect for clients that is important. The worker needs to feel comfortable walking into a room with users. That comfort can come from other places besides a lived experience. (Community based NSP, Manager)

We don't employ current users or people with a history of using from this area. Our clients don't like it. It's too messy. We employ both people who may have past-experience and people without. What's important is the empathy towards our client group, and employing people with social justice and who are strong on harm reduction and how it relates to drugs. (Community based NSP, Manager)

We are part of their life. We are more than an over the counter service. I would argue, and I have done, that we are a peer-based service. I struggle with the peer definition. No one has identified what a peer-based service is to me. We are important; we tick a box of peer-based service. We have empathy and non-judgement towards our clients. There is a very strong ownership and value put on this service by our clients. They have respect for us. They don't deal and use on the premises and not in the lane way at the back. (Community based NSP, Manager)

Specialist Alcohol and Other Drug Primary Health Services (SAPHS):

Specialist AOD primary health services were established in 2000-01 in five metropolitan Melbourne drug use hotspots (Greater Dandenong, Maribyrnong, Melbourne, Port Phillip and Yarra) to provide

a 'one-stop-shop' for vulnerable people including street-based injecting drug users and at-risk youth. These services are dedicated facilities in areas of high drug use people who inject drugs can access clean equipment, information, support and referral to treatment – including dedicated spaces that can be used by drug users.

These services incorporate in-house healthcare services and case management, harm reduction education, and information about drug use and related health issues. Primary health services also provide advice and information via linkage and referral to other appropriate services and outreach.¹⁶

Opioid Maintenance Therapy:

Opioid Maintenance Therapy (OMT) is an evidence-based, cost-effective public health strategy for managing opioid dependence. It has been declared by the World Health Organization as an essential medicine that can significantly improve and save lives and classified as medicines to which people, many who are marginalised, should have access at all times and in sufficient amounts. Ensuring that OMT is available in all communities also reduces the rate of criminal activity in the community, reduces overdoses, prevents the spread of BBVs and assists people to stabilise their lives, which helps them to lead more productive lives. The benefits of OMT, for opioid dependence are well documented, with studies showing a reduction in illicit drug use and improvement in health and wellbeing when people dependent on opioids are maintained on OMT.¹⁷ OMT gives people the opportunity to regain control of their lives and enables individuals to improve their physical and mental health, resume employment and/or education and strengthen their relationships with family, friends and the wider community. It also greatly reduces people's risk of fatal overdose.

People injecting and not receiving OMT are less likely to be engaged with the broader health system, are likely to be harder to reach to provide support with fewer opportunities to deliver appropriate additional harm reduction practices. OMT patients substantially decrease their use of heroin and other opioids, reduce their risk of mortality and morbidity and reduce the transmission risks of injection-related disease such as HIV/AIDS and hepatitis, improve their physical and mental health, resume employment and/or education and strengthen their relationships with family, friends and the wider community.^{18,19,20,21}

¹⁶ The Department of Health and Human Services, (2017) Alcohol and other drugs (AOD) program guidelines p. 11.

¹⁷ Feyer, A. Mattick, R., Schulman, C., et al (2008) A National Funding Model for Pharmacotherapy Dependence in Community Pharmacy. Sydney, NSW: Department of Health and Ageing, The Pharmacy Guild of Australia, National Drug and Research Centre, Price Waterhouse Coopers.

¹⁸ Gossop, M., Marsden, J., Stewart, D., & Kidd, T. (2003) The National Treatment Outcome Research Study (NTORS): 4–5 year follow-up results *Addiction* 98(3): 291-303.

There appears to be a dose-response protective effect of increasing methadone exposure on hepatitis C incidence. A Sydney based study (HITS-c study) shows that participation in OMT appears to be highly protective against hepatitis C incidence among people who inject drugs.²² Findings from the study show that OMT was protective against hepatitis C seroconversion and was associated with a reduced risk of incident infection among those who mainly injected heroin or other opioids. In addition to the Sydney study, three prospective cohort studies of illicit drug users in Vancouver, Canada, between 1996 and 2012, found that MMT (methadone maintenance therapy) exposure was protective against HCV seroconversion.²³ In two systematic reviews, opioid substitution treatment (OST) with methadone maintenance was found to be effective in reducing the risk of death and reducing risk of overdose death for those retained in treatment compared to those waiting for treatment, those who have left treatment or those that are in detoxification treatment.^{24,25}

The demand for OMT in Australia continues to increase, which is partly due to the dramatic increase in the level of opioid prescriptions. Ensuring OMT is accessible and affordable is an important strategy to help control prescription opioid misuse as well as heroin addiction and overdose.²⁶

While challenges associated with retaining people in OMT exist, these challenges are heightened for people recently released from prison. OMT in prison offers many benefits, including reducing drug related harms in the prison population, reducing the likelihood of substance use upon return to the community and a reduction of drug-related criminal activity post release. However, once released from prison there are challenges associated with maintaining pharmacotherapy. Most notably, this time is critical for most people released from prison who must negotiate housing, employment and reconnecting with family, friends and the broader community. Victorian State Department of Justice acknowledges the challenges experienced by post-release prisoners when they reintegrate back into

¹⁹ Maremmani, I., Pani, P., Pacini, M., et al. (2007) Substance use and quality of life over 12 months among buprenorphine maintenance-treated and methadone maintenance-treated heroin-addicted patients *Journal of Substance Abuse Treatment* 33 (1), 91-98.

²⁰ Lawrinson, P., Ali, R., Buavirat, A., et al. (2008) Key findings from the WHO collaborative study on substitution therapy for opioid dependence and HIV/AIDS *Addiction* 103(9), 1484-1492.

²¹ Teesson, M., Mills, K., Ross, J., et al. (2008) The impact of treatment on 3 years' outcome for heroin dependence: Findings from the Australian Treatment Outcome Study (ATOS) *Addiction* 103(1), 80-88.

²² White et al, Opioid substitution therapy protects against hepatitis C virus acquisition in people who inject drugs: the HITS-c study, *Med J Aust.* 2014; 201(6): 326-329.

²³ Nolan, s. Dias Lima, v. Fairbairn, n. et al (2014) The impact of methadone maintenance therapy on hepatitis c incidence among illicit drug users. *Addiction.* 2014 December; 109(12): 2053–2059.

²⁴ Mattick, R., Breen, C., Kimber, J., et al., 2009, Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence *Cochrane Database Syst Rev.* July 8;(3).

²⁵ Mathers et al., 2013, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bull World Health Organisation*, 91(2):102-32.

²⁶ Victorian Department of Health, Enhancing the Victorian Community Based Pharmacotherapy System, Directions Paper, January 2013.

the community by funding one month of pharmacotherapy treatment. This assistance is vital in not only helping to build some stability upon release from prison but essential in reducing a range of risks associated with injecting, including infection or re-infection with hepatitis C and opioid related overdose due to reduced tolerance to opioids.²⁷

By removing the drivers for much of the problematic behaviour associated with opioid addiction, OMT can provide people with an opportunity to make sustainable changes in their lives. In this way, OMT is an effective support to other therapeutic approaches (including withdrawal, counselling and rehabilitation) as it promotes the achievement of goals that are indicative of sustained change. For these reasons, it is a prime example of an addiction intervention that also enhances the prospects of long-term recovery.

Access to, and retention in, OMT is essential to successful treatment. OMT is most effective when patients remain in treatment for at least 12 months.²⁸ Most available evidence suggests many people leaving treatment will resume drug use.²⁹ Issues such as daily dispensing fees which range between \$30 and \$70, do impact on people's ability to access and stay on OMT.^{30,31} These daily fees compromise the public health and community benefits of an exceptional form of drug addiction treatment. Better access to OMT will help address growing rates of prescription opioid misuse and overdose. Under the present system, it is cheaper and easier to procure prescription opioids than OMT. Ensuring OMT is affordable is an important strategy to help stem prescription opioid as well as heroin addiction.

Outreach and engagement:

Outreach and community engagement is an important component to a number of Victorian services in their response to problematic drug use in their community. Mobile Drug Safety Workers (MDSW) and Overdose Response Workers support NSPs and emergency services. These outreach workers engage with people who use drugs providing education on harm reduction and treatment pathways.

²⁷ Stuart A Kinner, David B Preen, Azar Kariminia, et al., Counting the cost: estimating the number of deaths among recently released prisoners in Australia, *Med J Aust* 2011; 195 (2): 64-68.

²⁸ Ward, J., Mattick, R. & Hall, W. (Eds.) (1998) *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*, London: Harwood Academic Publishers.

²⁹ Winstock, A., Lintzeris, N., & Lea, T. (2011) 'Should I stay or should I go?' Coming off methadone and buprenorphine treatment *International Journal of Drug Policy* 22(1), 77-81.

³⁰ Lord, S., Kelsall, J., and Kirwan, A., et al (2014) Opioid pharmacotherapy fees: A long-standing barrier to treatment entry and retention, Centre for Research Excellence into Injecting Drug Use, Policy Brief No.8: September.

³¹ Rowe J. *A raw deal? Impact on the health of consumers relative to the cost of pharmacotherapy*. Melbourne: RMIT and the Salvation Army; 2007.

They provide sterile injecting equipment, information, education and referral to a range of health and social services.

A core element of the harm reduction outreach programs is to proactively engage with vulnerable people experiencing or at risk of harm from AOD who are not engaged with mainstream health, social support or AOD treatment services. These vulnerable communities include people who are homeless with minimal social support. These programs often operate in areas where there are high levels of drug use, particularly injecting drug use. They can provide crisis overdose response, overdose prevention workshops, education, client assessments, short-term case management and to support access to a range of social and health services.³²

Referrals to MDSW services are generally self-referred or received from other users, NSP and health services, support and user groups, or friends and families.

The Mobile Overdose Response Service (MORS) offer non-fatal overdose survivors support, information and assistance with access to treatment services.

Three examples of outreach and engagement:

- North Richmond Community Health employs two outreach workers to engage with people about their drug use. The team provides information about safe drug use, safe sex and the safe disposal of used injecting equipment and help with community education, advocacy, support and referrals to other agencies.
- Monash Health employs a mobile overdose response worker to provide overdose survivors, their families and friends and those at risk of overdose, non-medical care and support, debriefing and education. Pathways for access to health promotion and treatment services are also provided.
- Inner South Community Health, St Kilda has recently proposed a revised Mobile Health Overdose Service, which is designed to support contemporary best practise within the context of NSP service delivery by providing the following services: home delivery of injecting equipment; assertive outreach to deliver services via a specialised team; capacity building to support community organisations to provide programs and services that respond to local needs; and service development to improve the quality of services.

³² The Department of Health and Human Services, (2017) Alcohol and other drugs (AOD) program guidelines p. 11.

Pharmacotherapy Regional Outreach Worker (PROW) Program:

The PROW program was implemented in 2001-02 (originally called the Methadone Regional Outreach Worker Program) in response to a need to support rural GPs and pharmacists. The role of PROWs is to promote the use of opioid replacement therapy, to develop local and regional partnerships between GPs, Divisions of General Practice, pharmacists and drug treatment services, with the aim of increasing client access to treatment.³³ PROWs often have experience with training and education across a range of fields including nursing, social work, youth work and alcohol and other drugs. The outreach workers were originally located in four sites, which have expanded to the following eight sites in 2013:

- Barwon Health
- Bass Coast
- Bendigo Community Health Service
- Gippsland Lakes Community Health
- Latrobe Community Health Service
- Ovens and King Community Health Service
- South West Healthcare
- Sunraysia Community Health Service³⁴

Take-home Naloxone:

There is a commitment by the Victorian Government to ensure that naloxone is more widely available throughout the community beyond medical professionals. The main target group for take-home naloxone programs is people who inject drugs who use opioids. Within this broad population, those most at risk of opioid overdose include those who have overdosed previously and extremely marginalised groups such as;

- recently released prisoners,
- people who use opioids in public settings, and
- aging injecting drug users.

Programs now operate with the priority of making naloxone more widely available than ever before and to assist in getting naloxone into the hands of people most likely to witness someone

³³ King, T., Ritter, A. and Berends, L. (2010), *Victorian Pharmacotherapy Review*, Sydney: National Drug and Alcohol Research Centre.

³⁴ Victorian Government Department of Health (2013) *Enhancing the Victorian community based pharmacotherapy system: directions paper*, [Melbourne Department of Health].

overdosing. Most take-home naloxone programs in Australia have received only limited funding for their activities, which has limited the scope and reach of existing programs, despite the potentially life-saving initiative being relatively low cost. Naloxone supply is a priority of the Victorian Government with the announcement of subsidising the cost and expanding its availability to more Victorians who need it. Programs have been either seed funded for training people in administering naloxone, such as Penington Institute's COPE program, or incorporated within peer outreach programs such as the Peer Network Program operated by Harm Reduction Victoria.

Further details about naloxone are provided in section 1 and 2 of this report.

Peer Networker Program:

Harm Reduction Victoria (HRV) is funded to run a Peer Networker Program, which works alongside existing NSPs to increase availability of new injecting equipment especially for hard to reach groups. Through engaging with peers the program works to enhance accessibility to services for people who do not access NSPs, this includes distribution of new injecting equipment to reduce the need for sharing and the risk of hepatitis C transmission and offering training and support to reduce overdose. The program began in November 2013 with the first partnership between HRV and Western Region Health Centre/ Health Works. Monthly meetings with HRV and the peer workers provide an opportunity to share what is happening on the streets and the networks of peers engaged in the program. Currently the program operates in four locations.

While an agreement is reached with a local service provider, the program operates separate from the local organisation and is managed by HRV. An important component of the program, highlighted by HRV, is ensuring that independence is maintained from the local service. This allows peer workers to discuss and share information and issues with each other and not worry about having the service present, which the peer worker may engage with for their own personal needs. The philosophy of the program is to ensure the service is run and fully supported by a peer-based organisation, independent from the NSP or community health service. While this independence, or separateness, from the 'host' organisation is based on a range of reasons, there are missed opportunities as the host organisation does not benefit from the linkages with the community that these peers offer.

The program focuses on peer education and peer distribution of injecting equipment. Peers are paid \$100 a month and are paid to attend initial training. Training covers overdose, BBV and vein care, hepatitis C treatment, NSP handling, and data collection. HRV offers First Aid training which consists

of one day training and an online component, which most peers take up. Peers workers are required to collect data and report this back to HRV at monthly meetings. Data includes; Age (approximate), Gender, Target Group to identify groups who generally do not come into existing NSPs, post code, number and type of equipment given out, number of returned and topics discussed including education. Topics discussed usually cover safe disposal, BBV, safer using, vein care, police, overdose/naloxone and overdose prevention, new equipment and hepatitis C treatment. Basic data collected is similar to what is collected at NSPs and is considered important in identifying what is happening in specific networks and the broader injecting community.

Recruiting peers into the program is challenging, and in rural areas it is much harder to recruit peer workers. Peers tend not to be too young – usually aged 35-45 years. It is vital that peer workers show a strong commitment to the work. A range of rules for the program were set out with the first pilot. Over time the program has become much more flexible. It is important to acknowledge that the program is a fragile system. It is described as an organic program, needing to respond to current circumstances and what is happening in the lives of the peer workers, which may include prison time or treatment. There is a time limit on how long people stay in the program. This is of benefit for participants and for HRV. Usually six to 12 month is the right time. When people leave, they can nominate a friend to take their place, with no guarantees. Information collected by peer workers is shared with HRV and other peers at monthly meetings. The program also operates as an 'early warning system'.³⁵

DanceWize (formerly Ravesafe):

HRV is funded to run an outreach program which employs a peer education model to reduce harms associated with drugs at Victorian dance parties, festivals and night clubs. Through peer educators the program promotes safer drug use and safer partying for young people in Victoria's "dance party scene". Peer educators attend up to 28 events per year.

The 'Pharmacotherapy, Advocacy, Mediation and Support' (PAMS) Service:

The PAMS program provides confidential telephone-based information, support, advocacy, referral and mediation between opiate pharmacotherapy consumers and their direct service providers (Pharmacists, GP's etc.) on any pharmacotherapy client related issue in Victoria. The goal of the program, operated by HRV is to ensure program continuity for those on pharmacotherapy programs

³⁵ Consultation with Jane Dicka Harm Reduction Victoria's Drug Overdose Peer Educator

and to facilitate access to programs for those wishing to enter treatment for the first time or re-start treatment after a break.

METHODOLOGY:

Academic Literature:

Three searches for academic literature were undertaken, focusing on: (1) peer-based strategies; (2) overdose prevention, and; (3) peer-based overdose prevention strategies.

These were conducted across four databases: (1) ProQuest and (2) Scopus, which are both wide-reaching and are not limited to particular disciplines; (3) EMBASE, which comprehensively covers biomedical literature (including resources that can be accessed via MEDLINE and Cochrane Libraries), and (4) PsycINFO, which covers psychological, behavioural and social science research. Only material from the year 2000 onwards was included. A brief comparison of results between these databases showed some overlap of results, yet a significant increase in breadth when all four were utilized.

1. Peer-based strategies search:

The earliest search strategy combined the term 'harm reduction', with a variety of additional terms to indicate a peer-based strategy: peer outreach; peer led; peer-based; peer worker, and; peer leader. This was entered as: "harm reduction" AND "peer outreach" OR "peer led" OR "peer-based" OR "peer worker" OR "peer leader".

After a brief survey of the literature (as found through this search) and discussion with the project team, the additional terms 'peer education', 'peer support', 'peer helper', 'natural helper', and 'community-based outreach', were tested for inclusion. All the above terms, apart from 'peer helper' were included as they yielded extra relevant articles. With these additions, the final search term was: "harm reduction" AND "peer outreach" OR "peer led" OR "peer-based" OR "peer worker" OR "peer leader" OR "peer education" OR "peer support" OR "natural helper" OR "community-based outreach" (with minor variations to conform with database-specific requirements).

For inclusion articles had to be: (1) related to peer-based, harm reduction strategies, and (2) be focused on people who use drugs. Articles were excluded if they made mention of such strategies but did not make any substantial contribution to the literature. For example, an article that outlined the various harm reduction strategies in place in a certain country but contributed no analysis or original research would be excluded from the review.

Accounting for the overlap across the four databases, a total of 75 articles were retrieved.

2. Overdose prevention search:

The earliest strategy combined the term 'harm reduction', with a variety of additional terms to indicate overdose prevention responses: naloxone; overdose prevention; overdose response, and; overdose reversal. This was entered as: "harm reduction" AND naloxone OR "overdose prevention" OR "overdose response" OR "overdose revers*".

After a brief survey of the literature (as found through this search) and discussion with the project team, the additional terms 'overdose awareness', 'overdose education', 'fatal overdose' and 'overdose risk', were tested for inclusion. 'Fatal overdose' and 'overdose risk' were included as they yielded extra relevant articles.

The possibility to simplify the search to simply include 'harm reduction', 'naloxone' and 'overdose' was trialed, yet this broadened the search to include an unacceptable number of irrelevant articles, and therefore a variety of more specific terms were used. With the above taken into consideration, the final search terms used were: "harm reduction" AND "naloxone" OR "overdose prevention" OR "overdose response" OR "overdose revers*" OR "fatal overdose" OR "overdose risk*" (with minor variations to conform with the database-specific requirements).

For inclusion articles had to be: (1) related to overdose prevention strategies that fell under the umbrella of harm reduction, and (2) be focused on the overdose of either illicit drugs or illicitly used prescription drugs.

Articles were excluded on the following bases: (1) the research related to environments that were too-far removed from the Australian context to be relevant (e.g. a conflict zone in Afghanistan); (2) they were too abstractly theoretical for the present purpose; (3) were conference abstracts that met the inclusion criteria but did not include useful content (e.g. simply outlined the topics for discussion with no useful results); (4) they made mention of such strategies but did not make any substantial contribution to the literature.

Accounting for the overlap across the four databases, a total of 99 articles were retrieved.

3. Combined Peer and Overdose Search

After running the above two searches, a final search that covered both peer-based and overdose prevention strategies was run. Different to the first two searches, the final search did not require the term 'harm reduction' to be present, to catch articles that did not use this term.

This was entered as: overdose AND peer.

The result of 148 articles (when run through ProQuest) was deemed to be both broad enough, and manageable enough, that no further refinement of terms was necessary.

Articles included in this final search had to meet the inclusion criteria for either of the first two searches (see above).

Articles were excluded on the following bases: (1) they were concerned only with the epidemiology of overdose, rather than strategies to prevent it; (2) they outlined a study that was yet to be undertaken; (3) they made mention of such strategies but did not make any substantial contribution to the literature.

Accounting for the overlap across the four databases *and* the previous two searches, a total of 38 articles were retrieved.

4. Articles added post-search

17 journal articles were obtained after the above searches had been conducted. These were found predominantly through references of already retrieved articles and through recommendations from persons consulted for the purposes of this report.

Grey Literature:

Following the lead of similar literature review projects, grey literature was searched in the following ways:

- (1) systematically searched through the libraries and search engines of key organisations;
- (2) hand searched through the publications and resources sections of key organisation websites;
- (3) basic searches through Google, and;
- (4) hand searched through the reference lists of key documents.

Literature was included where there was a substantial focus on either peer-based strategies, overdose prevention, or both. This was determined by looking at the title, contents, and/or executive summary of the documents.

A full list of retrieved grey literature is available in appendix A.

Via key organisations:

Through consultation key organisations were identified for the grey literature search. 33 documents were retrieved through this method.

Via Google:

For each search conducted, the first 100 results were scanned, and for practical purposes only results that were themselves direct links to documents were assessed for inclusion.

These searches were:

- (1) 'Peer involvement and harm reduction'
- (2) 'Overdose prevention report' (as 'overdose prevention' by itself led to too many websites without documents).
- (3) 'Overdose and peer'.

In total, nine new documents were added to the collection of grey literature through this search.

Via key reference lists:

Only four documents were retrieved following a hand search of key reference lists. As a significant search had already been undertaken prior to this, the hand search was intended to find potential key texts only – major reports, recent articles that were right on topic, or other seemingly significant studies.

Final search result figures:

Combined, the three searches of academic databases resulted in: 186 full-text articles retrieved; 14 article abstracts; 25 conference paper abstracts.

46 grey literature documents were retrieved through the search, with an additional three documents added that were recommended by those consulted for the purposes of this report.

Post Search Exclusions:

Articles that had been initially included based on their titles or abstracts were excluded on the following bases:

- Conference abstracts for which a future resulting article was also picked up via the search.
- The study was conducted at a peer-run site, but was not concerned with peer-based strategies, overdose prevention or harm reduction in general.

- Articles which were primarily epidemiological studies that did not have a sufficient focus on peer-based strategies, overdose prevention or harm reduction in general.
- Articles which provided no more than generic background information on a topic.

3. INFORMATION AND EDUCATION PROGRAMS - OVERDOSE PREVENTION INTERVENTIONS AND PRACTICAL STRATEGIES TO RESPOND TO AN OVERDOSE

This section presents examples of models and interventions that could strengthen Victoria's approach to harm reduction and improve outcomes for individuals affected by drugs, including: information on education programs focusing on drug related harm reduction with specific attention to overdose awareness and practical strategies to respond to an overdose.

Attention is given to how best to share and deliver information about naloxone to individuals, families and others likely to witness an overdose. Examples are given where broad coalitions are formed to create programs, training and a range of accessible resources developed for the broad community and specifically for targeting risk groups and people who have a higher chance of being in contact with someone at risk of experiencing an overdose.

Overdose prevention interventions are implemented with the direct aim of preventing opioid overdose. Interventions act at different stages and levels of risk, addressing:

- (i) the general population, such as drug-use prevention interventions;
- (ii) people who use drugs when entering treatment;
- (iii) people currently using drugs, as is the case with harm reduction strategies; and
- (iv) those experiencing ongoing overdose, to reduce lethality.

European Monitoring Centre for Drugs and Drug Addiction claims that there is evidence that educational and training interventions with the provision of take-home naloxone decrease overdose-related mortality. However, the findings from the studies do not reveal which distribution model of overdose education and THN distribution is preferable.³⁶

³⁶ European Monitoring Centre for Drugs and Drug Addiction (2015), Preventing fatal overdoses: a systematic review of the effectiveness of take-home naloxone, EMCDDA Papers, Publications Office of the European Union, Luxembourg. p.3.

A CENTRAL OVERDOSE RESOURCE - OverdoseFreePA

OverdoseFreePA is a collaboration between six organizations including the Pennsylvania Department of Drug and Alcohol Programs, the Allegheny County Medical Examiner's Office, and several single county authorities along with University of Pittsburgh School of Pharmacy and 16 Pennsylvania communities involved with overdose prevention and recovery activities. This collaboration is to increase community awareness and knowledge of overdose and overdose prevention strategies, as well as to support practices and initiatives that will decrease drug overdoses and deaths in the communities.

The group organised as the Overdose Prevention Coalition (OPC) to develop a free, meaningful, credible, and accessible resource in the overdosefreepa.org website to support multidisciplinary efforts to reduce overdose and overdose deaths. The website was launched in August 2014. Advisory committees were formed for each of four main interest groups: family and friends; criminal justice; school and work; and health care professionals. Resources have been developed to be used by all Pennsylvanians to learn more about overdose and the way Substance Use Disorders (SUD) affect people, families and communities. By working together to create a central overdose resource, the treatment and prevention efforts in these communities will be increased. The overall goal of this project is to increase community awareness and knowledge of overdose and overdose prevention strategies as well as to support initiatives aimed at decreasing drug overdoses and deaths within the participating counties.

The website serves as a 'town square' of information to help professionals and communities prevent overdose and overdose deaths. Of note are the following sections from the website:

1. The Find Naloxone page lists pharmacies throughout Pennsylvania that stock naloxone.
2. A collaboration with county coroners' provides timely collection and access to overdose-related data to improve our understanding of the overdose impact.
3. Information on prescription drug take-back program to assist in proper disposal of unused prescription medications
4. For local communities, there are links to a range of reliable neighbourhood resources to assist in bringing people and groups together to support and help one another.
5. Education pages, built with the input of professionals and community members on the front lines, providing an extensive resource of information.
6. A list of speakers for each participating OverdoseFreePA county. A list of topics is also provided.

Reference and resource:

<http://www.overdosefreepa.pitt.edu/>

TAKE-HOME NALOXONE

RESEARCH ON TAKE-HOME NALOXONE TRAINING AND DISTRIBUTION:

Accumulating international evidence shows that the provision of naloxone, with appropriate training, to people (including friends, family, and service providers) who use or come into contact with people who use opioids can lead to successful opioid overdose reversals. Naloxone is a remarkably safe intervention with few, if any adverse effects.

“One of the main challenges for take-home naloxone programmes is to achieve sufficient coverage of at-risk populations, so that substantial reductions in opioid overdose deaths can be attained.”³⁷

The early literature on take-home naloxone was primarily focused on street-based opiate injectors who frequented harm reduction services such as NSPs. However, in more recent years the focus on take-home naloxone – in research and programs – has expanded to include a range of key populations and their interactions with different services/institutions. This expansion is in line with the 2014 WHO recommendation that all ‘people likely to witness an opioid overdose should have access to naloxone and be instructed in its administration to enable them to use it for the emergency management of suspected opioid overdose’. WHO also acknowledges that the quality of evidence to support this recommendation is very low.³⁸

Over the past five years, naloxone has dominated the overdose prevention literature, both published and grey. What must be emphasised is that while administering naloxone will reduce the number of witnessed opioid overdoses which result in death, it does not address the underlying causes of opioid overdose. As outlined by WHO, to further reduce the number of deaths from opioid overdose other approaches need to be considered, including:

- Monitoring opioid prescribing practices;
- Curbing inappropriate opioid prescribing;
- Curbing inappropriate over the counter sales of opioids;
- Increasing the rate of treatment of opioid dependence;
- Ensuring OMT is available and accessible;

³⁷ European Monitoring Centre for Drugs and Drug Addiction (2016), Preventing opioid overdose deaths with take-home naloxone: Publications Office of the European Union, Luxembourg. p.5.

³⁸ World Health Organization 2014, *Community management of opioid overdose*, World Health Organization, Geneva. p.x.

- Raising awareness about opioid overdose;
- Linking those who are vulnerable to relevant services; and
- Maximising the role of needle and syringe programs.

Based on the probability of witnessing an overdose, three target populations for take-home naloxone programmes were identified in early programs such as the Chicago Recovery Alliance (1996): where people who use drugs, carers (close contacts of users including peers and family members) and agency staff are likely to interact with users. These three groups still apply today, with the inclusion of prescription opioid users (e.g. chronic pain sufferers) who may also benefit from take-home naloxone.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) 2016 report, *Preventing opioid overdose deaths with take-home naloxone*, states that training for naloxone administration needs to be directed to three broad groups, people who use drugs, carers and agency staff:

1. People who use drugs, including:
 - (1) Current opioid injectors;
 - (2) Heroin injectors upon release from prison;
 - (3) Former opioid users upon release from detox/rehab; and
 - (4) Individuals starting methadone maintenance programs.³⁹

2. Carers

Carers include family members, friends and other close contacts of people who use drugs. Research from the late 1990s found that most overdoses occur either in homes or in the presence of others (e.g. peers, family members or partners) and therefore close contacts of opioid users were identified as the second target group for take-home naloxone training and distribution. A postal survey in England found that 90 per cent of close contacts with people who use drugs wanted training in overdose management and how to administer take-home naloxone.⁴⁰

A recent study by Williams found that training family members in emergency recovery procedures and naloxone administration led to greater overdose-related knowledge than with family members

³⁹ European Monitoring Centre for Drugs and Drug Addiction *op cit*.

⁴⁰ Strang J, Manning V, Mayet S, et al Overdose training and take-home naloxone for opiate users: prospective cohort study of impact on knowledge and attitudes and subsequent management of overdose. *Addiction* 2008; 103 (10) 1648-57

who had received only basic information. The study found that these gains from training were maintained over a three-month follow-up period.⁴¹

3. Agency staff

Transferring knowledge about the benefits of naloxone from agency staff occurs via: 1) standard medical settings/healthcare providers, and 2) Needle and Syringe Programs. Several studies, cited in a 2016 EMCDDA report *Preventing opioid overdose deaths with take-home naloxone*, have explored if healthcare providers would be supportive of the practice. Mixed results were found, as evident by the following study results.⁴²

A New York-based postal survey of professionals with prescribing authority (i.e. physicians, physician assistants and nurse practitioners) showed that a third were willing to prescribe naloxone, whereas two-thirds of respondents were unsure or unwilling to do so.⁴³

A survey of emergency service providers in Baltimore (Maryland) revealed overall negative attitudes towards take-home naloxone programs, with 56 per cent stating that they felt that training would not have an impact on drug-related deaths.⁴⁴ Willingness to prescribe was correlated with positive attitudes towards drug users, and vice versa.⁴⁵ Some of the areas of potential concern raised by clinicians mirror those highlighted by drug users, such as competency in administering naloxone.⁴⁶

Effectiveness of take-home naloxone:

A 2016 published systematic review by McDonald and Strang⁴⁷ assesses the effectiveness of take-home naloxone, with two specific aims:

- (1) to study the impact of take-home naloxone distribution on overdose-related mortality; and
- (2) to assess the safety of take-home naloxone in terms of adverse events.

⁴¹Williams A, Marsden J, and Strang J, Training family members to manage heroin overdose and administer naloxone - randomised trial of effects on knowledge and attitudes, *Addiction* 2014 109(2): 250-9.

⁴² European Monitoring Centre for Drugs and Drug Addiction (2016), *Preventing opioid overdose deaths with take-home naloxone*: Publications Office of the European Union, Luxembourg, p52.

⁴³ Coffin, P., Fuller, C., Vadnai, L. et al (2003) Preliminary evidence of health care provider support for naloxone prescription as overdose fatality prevention strategy in New York City *Journal Urban Health*, Jun; 80 (2): 288-90.

⁴⁴ Tobin, KE, Gaasch, WR, Clarke, C, et al. 2005, 'Attitudes of emergency service providers towards naloxone distribution programs', *Journal of Urban Health*, vol. 82, no. 2, pp. 296-302.

⁴⁵ Beletsky, L., Ruthazer, R., Macalino, G. et al. (2007) Physicians' Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose: Challenges and Opportunities *Journal of Urban Health*, 84(1), 126-136.

⁴⁶ Tobin *op.cit.*

⁴⁷ McDonald R. and Strang J. (2016) Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria, *Addiction*, 111, 1177-1187.

Evidence was evaluated using the nine Bradford Hill criteria for causation, devised to assess a potential causal relationship between public health interventions and clinical outcomes when only observational data are available.⁴⁸ From the 22 observational studies which met eligibility criteria, it was found that take-home naloxone programs are effective in terms of all nine Hill criteria. Take-home naloxone programmes reduce overdose mortality among programme participants and in the community and have a low rate of adverse events. In addition, the risk associated with take-home naloxone programmes is relatively low. In studies with systematic follow-up, one death was reported among 123 overdose victims who were administered take-home naloxone. Moreover, there is no empirical evidence to support the concern that take-home naloxone programs might encourage heroin use. Two studies reported decreased drug use among take-home naloxone program participants at follow-up, with a more recent study finding no overall change in the frequency of heroin use across take-home naloxone recipients. This is the first published application of the Bradford Hill criteria to assess the international evidence base on take-home naloxone.

In 2015, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) conducted a systematic review of the available studies on take-home naloxone to reverse opioid overdose. The review included 21 studies. Evidence from one interrupted time-series study, involving 2,912 opioid users at risk of overdose in 19 communities followed up for seven years, found that educational and training interventions complemented by take-home naloxone decreases overdose-related mortality. There is weaker, but consistent, evidence that similar interventions for opioid-dependent patients and their peers effectively improve knowledge while forming positive attitudes to the correct use of naloxone and the management of witnessed overdoses.⁴⁹

⁴⁸ The Bradford Hill criteria are considered a standard tool to assess the impact of broad-based public health interventions where it is not ethically feasible or operationally impractical to conduct RCTs (Randomised Control Trials).

⁴⁹ European Monitoring Centre for Drugs and Drug Addiction (2015), *Preventing fatal overdoses: a systematic review of the effectiveness of take-home naloxone*, EMCDDA Papers, Publications Office of the European Union, Luxembourg. p. 11.

Scotland

In 2007, Scotland launched three take-home naloxone pilots (Glasgow, Lanark and Inverness) and became the first jurisdiction to implement take-home naloxone nationally in 2010. Guidelines were passed shortly after in 2011 to allow naloxone to be provided to services without prescription for use in an emergency and to be stored in non-medical facilities. The program allows for take-home naloxone to be distributed in the community as well as in prisons for prisoners upon release.

The Scottish government funds the program centrally and all service providers are reimbursed for the number of naloxone kits issued. Among Scottish prisoners supplied with take-home naloxone, mortality within four weeks after release had decreased to 4.7 per cent by 2013 compared with the pooled 2006-19 baseline of 9.8 per cent. Similar reductions of overdose deaths were observed after hospital discharge. Since the government started supporting take-home naloxone in 2011, the number of heroin-related deaths within four weeks of prison release has decreased gradually every year, coinciding with the steady increase in the number of take-home naloxone kits provided.

References:

Bird, S., Parmar, M., Strang, P., (2015) Take-home naloxone to prevent fatalities from opiate-overdose: Protocol for Scotland's public health policy evaluation, and a new measure to assess impact. *Drugs* (Abingdon Engl) Feb; 22 (1): 66-76.

McAuley A., Best D., Taylor A., et al. (2012) From evidence to policy: The Scottish national naloxone programme. *Drugs: Education, Prevention & Policy* 19: 309–319.

NALOXONE IN AUSTRALIA:

Getting naloxone into the right people's (users/friends/family/carers/service providers) hands is happening in Australia, but not to adequate scale. The focus has been overwhelmingly on supply when there continues to be challenges with demand for naloxone. Ultimately, effective engagement of people who use drugs in overdose prevention will require a reasonable balance of low cost naloxone supply, quality service and convenient access. Successful implementation has relied a great deal on 'champions' – that is, personally committed workers and health professionals – as distinct from broad organisational support. With the continual promotion of naloxone along with training with different groups and in a range of contexts, there is no specific incentive for agencies to integrate overdose prevention in their day-to-day practice.

Until very recently naloxone could only be prescribed by a doctor, the co-scheduling of naloxone on Schedule 3 now allows pharmacists to dispense naloxone without a prescription. However, with no PBS subsidy for Schedule 3, what has been gained in convenience has been lost with prohibitive cost. As many of the programs highlighted in this section show, access to naloxone needs to be both convenient and affordable to allow health and human services workers to focus on what they do best: provide an engaging, high quality, health-oriented service to their clients.

With naloxone access no longer tied solely to prescription, now is the time to develop and incorporate innovative models of distribution that reflect its safety and ease of use. From this literature review it is evident that, around the world, naloxone is being provided to laypeople and non-medical professionals in a range of settings to use when needed. For example; in parts of the US, police officers administer nasal spray naloxone when responding to overdoses; in the UK, large and successful trials have seen recently released prisoners with a known history of opioid use receive naloxone. Additional ways to enable NSPs, drug treatment, outreach and other relevant services to directly dispense free naloxone to clients who need it (and train them to use it) is reflected in this section.

Naloxone training in Australia is provided in a range of settings and locations (street, treatment agency, training room, NSPs etc.) and durations (ranging from five minutes to well over an hour), with many protocols, materials and videos available online. Evidence suggests that even brief trainings is effective, with one recent study showing that fewer than 10 minutes of training in intranasal naloxone administration is sufficient for successful reversals.⁵⁰

EXPERIENCES OF 15 SERVICE PROVIDERS REGARDING PROVISION OF TAKE-HOME NALOXONE TO PEOPLE WHO USE OPIOIDS IN VICTORIA

A recent study published in 2016 by Dwyer, Fraser and Dietze investigated the experiences of 15 service providers concerning provision of take-home naloxone to people who use opioids in Victoria.⁵¹ Major findings from study include:

Service providers see one of the benefits of putting the ability to save lives and reduce the potential of adverse effects of overdose in the hands of users as empowering users. This increased confidence

⁵⁰ Behar E, Santos G., Wheeler, E., Rowe, C, & Coffin, P., (2015) Brief overdose education is sufficient for naloxone distribution to opioid users. *Drug and Alcohol Dependence*, 148, 209-212.

⁵¹ Dwyer R. et al. 2016, Benefits and barriers to expanding the availability of take-home naloxone in Australia: A qualitative interview study with service providers, *Drugs Educ Prev Pol*, 2016; 23(5): 388–396.

and self-esteem in those who have received the training and is seen as potentially fostering a culture in which naloxone will be well-known and in demand.

The research countered the idea that naloxone would increase opioid consumption due to the perception of a 'safety net'. Some service providers raised the issue of 'violence or abuse' by those who had been revived by naloxone, but noted that the Harm Reduction Victoria intervention recommended lower doses to avoid/mitigate this.

Importantly, risks that were highlighted by providers were subsequently debunked as 'myths' that either were not true (i.e. not supported by evidence or their experiences) or could be overcome with adequate training. Authors claimed that their research provides evidence of the successful operational implementation of peer-to-peer take-home naloxone delivery within a range of drug primary health services and NSPs. It was noted that further research is required to better understand the implications of and impediments to scale-up of naloxone based public health interventions.

TRAINING IN NALOXONE - AN AUSTRALIAN SNAPSHOT

Two models have emerged across Australia in how naloxone is administered and where training has been directed. As you get further away from specialised drug services (NSPs and AOD) other relevant services include mainstream services which also reach families of people who use drugs. The following examples capture both specialised and mainstream public health sites.

Implementing Expanded Naloxone Availability in The ACT (I-ENAACT) Program, 2011-2014:

The Canberra Alliance for Harm Minimisation and Advocacy (CAHMA), ACT Health, the Alcohol Tobacco and Other Drug Association ACT (ATODA) and a multidisciplinary group of stakeholders initiated Australia's first take-home naloxone (THN) program in April 2012. The program involves training and the supply on prescription of THN to eligible participants who are not health professionals. Eligible participants include people who may at some time need naloxone, an ex or current opioid user (heroin, morphine, etc.) who has gained the required level of knowledge to safely administer naloxone (decided through interview with a doctor at end of training course). Family and friends of opioid users can attend the training and can obtain naloxone over-the-counter at community pharmacies throughout Canberra. The program involves attending a three-hour training course, with participants required to bring along their Medicare Card. It is a requirement for participants to attend a brief consultation with the doctor at the end of the training to confirm that

they know how to safely administer naloxone. Participants are then provided with take-home naloxone.

Eighteen inmates at the Alexander Maconochie Centre (Canberra's prison, which holds both sentenced prisoners and those on remand) were trained in overdose prevention and naloxone administration as part of the program. Some participants received prescription naloxone after release. Four workshops were held at the prison. Several participants from the Alexander Maconochie Centre were trained in the prison and collected naloxone prescriptions at the CAHMA office post-release, but not all could be followed-up for collection of naloxone.

An evaluation⁵² of the program (2011-2014) was positive, detailing a range of delivery models to be considered. Given the success of the ACT program and the broadening policy landscape of non-medical access to naloxone, it was recommended that internationally recognised delivery models should be considered for use in the Australian context. These were listed as:

- Delivery of training and naloxone provision across a range of settings:
 - peer-to-peer in drug user organisations
 - one-on-one in pharmacies
 - one-on-one in General Practice settings
 - one-on-one in opioid substitution therapy (OST) settings
 - workshops or one-on-one in specialist drug treatment and withdrawal services
 - workshops or one-on-one in prisons and other correctional services
 - workshops or one-on-one in Aboriginal Medical Services.
- Delivery of training and naloxone provision to a range of people, targeting those who use opioids as well as those in regular contact with people who use opioids:
 - those in drug user organisation networks
 - those on OST
 - those in specialist drug treatment services
 - friends and family of those who use opioids
 - at risk prisoners as well as those under community-based court order or parole
 - the alcohol and other drug workforce
 - NSP workers

⁵² Olsen, A., McDonald, D., Lenton S., et al. 2015, Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENACT) Program', 2011-2014; final report, Canberra.

- Aboriginal Medical Service staff.
- A variety of training delivery models:
 - one-on-one
 - group workshops
 - brief training on naloxone administration
 - comprehensive training on overdose recognition and response
 - a combination of the above⁵³

The evaluation acknowledged different models for naloxone access, and the possible implications of these models to be examined for the ACT. These models included:

- Delivery of training and naloxone provision across a *range of settings* including:
 - one-on-one in pharmacies,
 - one-on-one in General Practice settings,
 - one-on-one in OST settings,
 - workshops or one-on-one in specialist drug treatment services,
 - workshops or one-on-one in prisons and other correctional services, and
 - workshops or one-on-one in Aboriginal Medical Services.

Reference:

Lenton S, Dietze P, Olsen A, et al, Working together: Expanding the availability of naloxone for peer administration to prevent opioid overdose deaths in the Australian Capital Territory and beyond, *Drug Alcohol Rev.* 2015 Jul; 34(4): 404-11

The West Australian Peer Naloxone Program:

The West Australian Peer Naloxone Program is a collaboration between the Drug and Alcohol Office (DAO), now the Mental Health Commission, Workforce Development Branch, and the West Australian Substance Users Association (WASUA). The program, which began in 2013, was designed to reduce opioid overdose morbidity and mortality through: improved overdose identification; increased effectiveness of interventions in opioid overdose management; enhanced provision of comprehensive overdose identification and management training; provision of take-home naloxone by prescription to eligible participants in the program; reduction in opioid overdose through overdose prevention education.

⁵³ Olsen *ibid* p.57.

The program was developed from the experience with OPAM (Overdose Prevention and Management Project).

Recruitment was conducted via;

- information provided through existing peer networks and word of mouth,
- information fliers in targeted settings that provided services for opioid users and organisations that support families and friends of opioid users,
- information sessions for stakeholder groups and in targeted settings,
- promotion through the West Australian Network of Alcohol and Drug Agencies (WANADA) sector newsletter, and
- regular agenda items through WA alcohol, tobacco and other drugs sector governance bodies.

Sites for training included: Needle syringe/exchange programs run by DAO; Primary healthcare centres; Homeless shelters and drop-in-centres; alcohol and other drug services; and prisons.

Training venues were accessible via public transport.

Training was delivered by 1 x peer educator + 1 x drug and alcohol trainer/first aid instructor.

The training component of the program comprised a two-hour small group session which covered: risk factors for overdose; myths and facts about overdose and about calling an ambulance; first aid response to overdose (DRSABC); when and how to give naloxone by intramuscular route using Minijet® (DRSABNC); post naloxone monitoring and support; and communication with ambulance officers. Immediately after the training session, participants who were eligible to be prescribed naloxone were assessed by GP who attended the session. If satisfied, the GP dispensed naloxone to the participant as part of a naloxone kit. Each naloxone kit, which was provided at no cost under the program, included: two Minijets® containing 0.4mg naloxone; two 23g needles suitable for intramuscular (IM) injection; four alcohol wipes (swabs); two face shields; two pairs of disposable gloves; a sharps disposal tube; a copy of the “Stop The Drop” step-by-step guide to managing an overdose, including naloxone administration; a business card sized ‘Training Certificate’ which included WASUA contact numbers for participants to provide to police if they were questioned about having naloxone in their possession; and a contact card for follow up evaluation.

Key Training Session Messages:

- Wake a mate – he may not be just ‘sleeping’

- How to clear and open the airway and perform EAR.

The evaluation⁵⁴ showed positive results across all outcome measures, with consistent appropriate use and overdose reversals (32 from 153 participants) reported. Unintentional and positive consequences from the training included; a sense of empowerment and increased confidence among participants.

Reference:

Nelson, M., Lenton, S., Dietze, P., Olsen, A. and Agramunt, S. (2016). Evaluation of the WA Peer Naloxone Project – Final Report. National Drug Research Institute, Curtin University, Perth, Western Australia.

Overdose Prevention and Emergency Naloxone (OPEN) In NSW:

The Overdose Prevention and Emergency Naloxone Project⁵⁵ is an intervention to reduce opioid overdose-related morbidity and mortality. The project began in 2012 as a collaboration between Kirkton Road Centre and The Langton Centre. The program evolved from initially involving a comprehensive training workshop conducted for groups (60-90 mins) to become a brief intervention (10-20 mins) to be provided on-demand and throughout the course of standard care. Efforts were made to have the brief intervention model approved by NSW Health to make it widely usable and enable confidence in its legitimate status. While the model has been taken up by various other organisations since it had gone through the approvals process it has, after this point, stagnated.

Positive experiences were reported by the participants who applied the knowledge and skills gained in the training session. At least 30 opioid overdose reversals were reported by 18 participants, including one overdose of a participant themselves (administered by a witness), and nine participants who witnessed and responded to two or more opioid overdoses since receiving their overdose management packs. Of these 18 participants, 17 reported that naloxone was used to manage the overdose. A presentation about the program and specifically translating the program across a range of settings was given at the Centre for Research Excellence into Injecting Drug Use (CREIDU) Colloquium, 2016. The presentation can be viewed at:

<https://www.youtube.com/watch?v=ajLVPmVR3GU>

⁵⁴ Nelson, M., Lenton, S., Dietze, P., et al. (2016) Evaluation of the WA Peer Naloxone Project – Final Report. National Drug Research Institute, Curtin University, Perth, Western Australia.

⁵⁵ Lintzeris, N. (2016) *Translating take-home naloxone from a good idea to mainstream practice across drug and alcohol, Needle and Syringe Program and peer worker settings in New South Wales*, online video, 17 September, CREIDU Colloquium 2016, viewed 7 February 2017, <<https://www.youtube.com/watch?v=ajLVPmVR3GU>>

Throughout the project a range of challenges were addressed, including client and staff time constraints. It was identified early in the program that the training session needed to be shorter and opportunistically offered. An abridged format has been developed and takes approximately 15-20 minutes and is designed to be delivered as part of routine clinical appointments.

Further research is currently underway to demonstrate:

- (1) the ability for this brief intervention model to be delivered in specialist AOD, NSP and peer outreach services;
- (2) the effectiveness of the intervention and the cost-benefits of it; and
- (3) the feasibility, sustainability, and scalability of the intervention across the state.

Reference:

Lintzeris, N 2016, *Translating take-home naloxone from a good idea to mainstream practice across drug and alcohol, Needle and Syringe Program and peer worker settings in New South Wales*, online video, 17 September, CREIDU Colloquium 2016, viewed 7 February 2017, <https://www.youtube.com/watch?v=ajLVPmVR3GU>

Drug Overdose Prevention Education (DOPE) In Victoria:

This program, implemented by HRV, began in 2013.⁵⁶ The primary aim of DOPE is to reduce the incidence of both fatal and non-fatal overdose among current heroin, amphetamine type substances and poly drug users in Victoria. Peer education workshops are delivered to groups of up to ten current users. Approximately 25 workshops are held every year at a range of services attended by people who use drugs. The program also caters for refresher workshops. The program for the workshop covers:

WORKSHOP PROGRAM (HEROIN AND OTHER OPIOIDS):

PART 1: OVERDOSE PREVENTION (HEROIN)

- Recent overdose research – what do we know?
- The concept of risk and taking risks
- Risk factors for overdose (we talk about risk factors all through the workshop)
- Ways to reduce the risks
- Drug classes and effects, including drug interactions, tolerance and drug half-life.

⁵⁶ Dicka, J 2016, *The DOPE project: where it's been and where it's going?*, online video, 21 September, CREIDU Colloquium 2016, viewed 7 February 2017, <https://www.youtube.com/watch?v=LLBuKWb95Ek&t=11s>

PART 2: OVERDOSE RECOGNITION & RESPONSE (HEROIN)

- Signs and symptoms of overdose
- Common overdose myths
- What to do in the event of an overdose, including; Calling an ambulance, Police overdose policy and the recovery position.
- Hands on resuscitation training (mouth to mouth with the resuscitation dummies)

PART 3: OVERDOSE PREVENTION (AMPHETAMINES & OTHER ATS)

- Managing your use
- Looking after your mates
- Adverse drug effects: Physical
- Adverse drug effects: Physiological
- Risk factors associated with amphetamine use.

PART 4: OVERDOSE RECOGNITION & RESPONSE (AMPHETAMINES)

- Signs and symptoms of overdose
- What to do in the event of an overdose/ heart attack including; calling an ambulance and the recovery position.
- Hands on resuscitation training using resuscitation dummies.⁵⁷

Like the NSW OPEN program, DOPE has been shifting away from longer, group-based workshops, towards more flexible and opportunistic brief interventions. The duration varies depending on the needs of the person being trained. New areas for intervention are being pursued, such as training key persons staying in rooming houses, and providing take-home naloxone to prisoners post-release (through referrals from Burnet Institute's PATH cohort study). In addition to the formal organised trainings with clients of NSPs, HRV is now undertaking one-on-one opportunistic trainings.

References:

1. <https://www.youtube.com/watch?v=LLBuKWb95Ek&t=11s>
2. <http://hrvic.org.au/overdose/the-project/>

⁵⁷ Harm Reduction Victoria DOPE project page: <http://hrvic.org.au/overdose/the-project/>

Community Overdose Prevention Education (COPE) In Victoria:

COPE is a community-based opioid overdose prevention initiative seed funded by the Victorian Department of Health and Human Services for two years. The program began in 2013 and is implemented by Penington Institute. The program is built upon the recognition that a wide range of health and community workers come into contact with people at risk of opioid overdose. Properly supported, these workers are ideally placed to engage and train their clients in how to use naloxone, and to help coordinate the health professional who can supply it.

Initially NSPs and drug treatment agencies were prioritised, however as the program evolved the types of agencies involved also expanded to include mental health, general health and homelessness and Aboriginal health organisations. The program has been promoted to over 300 health professionals, including hospital emergency department physicians who work first-hand with people affected by overdose and understand the life-saving potential of naloxone.

To date, the COPE program has trained over 428 workers in 37 agencies across Victoria. In turn, naloxone training has been provided to 793 potential overdose witnesses, with 765 prescriptions provided. It is very difficult to obtain accurate data on the numbers of overdose reversals, as this relies on reporting back from clients. However, an example of COPE's effectiveness is evident at Barwon Health, which the state government recently identified as an overdose hotspot: Barwon Health has reported 21 lives saved as a result of implementing COPE.

COPE runs on a 'train the trainer' model where frontline workers from various organisations are given the skills and materials to provide take-home naloxone training to at-risk people who access their services. Training and support is offered to organisations that work with clients at risk of opioid overdose, as well as other individuals who are potential overdose witnesses (family members and friends). These individuals are then trained by COPE partners, learning how to:

1. prevent opioid overdose;
2. recognise opioid overdose; and
3. respond to an opioid overdose, including the administration of naloxone via intra-muscular injection.

A COPE Network has been convened by Penington Institute which provides an opt-in coordination, networking and information opportunity for partner organisations. The Network meets roughly four times a year. The COPE program has conducted awareness raising events with general practitioners, pharmacists and emergency personnel, regarding implementing the program throughout Victoria.

Participating partner organisations have, so far, largely been primary health, treatment and other community organisations. As reflected in numerous programs, there has been a move away from long and onerous training and toward simple, brief interventions to allow partner organisations to apply overdose prevention in a range of settings (to ‘meet the individual where they are’).

A range of external issues have created challenges for the COPE program:

1. A reliance on the personal commitment of individual staff, as opposed to broad organisational support for overdose prevention within some COPE agencies, have made implementation vulnerable to staff changes and shifting priorities.
2. GPs remain reluctant to prescribe naloxone.
3. COPE coordinators face challenges in designing service delivery models that navigate the unduly complex naloxone prescribing and dispensing requirements (coordinating doctors, pharmacists and hard-to-engage client groups).
4. The two-year funding period overlapped with a major restructure of the alcohol and drug sector.

Where to next for COPE?

To improve the effectiveness of the COPE program, Penington Institute is exploring an ‘auspicing’ model where key workers at participating organisations will be encouraged to use their existing local connections to broaden the reach of take-home naloxone training. It is anticipated that this will create stronger networks of people who have naloxone and know how to use it.

An internal review conducted in 2016 of COPE highlighted that the program has not reached its full potential. All stakeholders agreed that a precondition for successful COPE implementation is to have at least one person embedded within an organisation to act as a local champion. This role is not restricted to an existing health worker position, but could be fulfilled by a peer worker integrated within the organisation. A champion is generally driven by the general merits of overdose prevention – not just the defined accountabilities of their role. They:

- provide focus and help to maintain the legitimacy of the program within their organisation;
- coordinate different service providers to ensure naloxone training and provision is as simple and client-centred as possible; and
- can identify and generate new champions and collaborators through their leadership and energy.

It is acknowledged that while the presence of local champions is essential, they do not guarantee success. Champions need to work in a supportive environment, have the knowledge, authority or capacity to embed naloxone interventions within their organisations. One high performing local champion described COPE as a legitimising force for both the champion and their employer for what they already wanted to do. While there are likely to be many local champions among partner organisations, these people need to be activated or empowered to be effective. They would likely benefit from proactive communications, tailored support, tools and connections provided by a coordinating body.

Local champions are essential, but need to be supported and connected to succeed. All stakeholders agreed that having strong links to local, supportive service partners – especially GPs to prescribe naloxone and pharmacists to dispense it – is essential. High performers have achieved a coordinated approach; low and slow performers cite this as one of the largest implementation hurdles. Indeed, lack of service coordination appears to be reflected in COPE’s program data. Given general barriers to help-seeking among opioid users, the very high (96 per cent) rate of filled naloxone scripts suggests only organisations with a viable strategy for putting naloxone in clients’ hands are starting to train them.

- Barwon Health and Footscray Health Works noted their integrated training and dispensing model, which enables clients to walk in the door, undertake training and walk out the door with naloxone in hand, is a big part of their success.
- Monash Health has used its connections to its Area Pharmacotherapy Network to identify supportive GPs and pharmacists and grow the quality of its service to clients. In the future, Monash plans to use the network to advocate for naloxone prescribing/dispensing which will expand the reach of its COPE activities.

There is an on going challenge to make COPE meaningful in the day to day operations of an organisation. It is acknowledged that there needs to be targeted support to build capacity. There also is a need to engage clients better, with the ongoing challenge of getting clients to get a script filled. There was an overall sense that, through organisations’ general outreach activities, client engagement was possible if the ‘behind the scenes’ systems worked better.

Reference:

<http://www.copeaustralia.com.au/>

FAMILY MEMBERS, PARTNERS AND OTHERS WHO ARE LIKELY TO WITNESS AN OVERDOSE

Most opioid overdoses occur in private homes and most of these are witnessed by close friends, a partner or family members.⁵⁸ Family members of people who use heroin have been generally overlooked by overdose prevention programs. Strang and colleagues make the claim that two-thirds of opioid overdose fatalities could potentially be avoided by emergency naloxone administration by peers.⁵⁹

A study by Williams and colleagues evaluated the effectiveness of training on overdose management and emergency naloxone administration for family members and other carers or significant others. The aim of the training was to increase knowledge and positive attitudes towards overdose management and take-home naloxone administration, and to record events of witnessing and managing an overdose during a short-term follow-up. The study documented group-based training in take-home naloxone vs an information only control group. Training events took place in addiction treatment services in three locations in England. The take-home naloxone-trained group showed greater overdose related knowledge at three month follow-up and more positive attitudes to naloxone.

The findings from this study demonstrate the positive effects of THN training on both knowledge of, and positive attitudes towards, overdose management. THN training for family members of heroin users increases opioid overdose-related knowledge and competence and these benefits are well retained after three months. It also shows that THN training is superior to providing only information. The study has also demonstrated that family members, a group who have long been overlooked, can be trained effectively to deal with a heroin overdose including emergency naloxone administration. Training of family members should now be provided routinely to help prevent fatal outcomes from opioid overdose events.

Reference:

Williams A, Marsden J, and Strang J, Training family members to manage heroin overdose and administer naloxone - randomised trial of effects on knowledge and attitudes, *Addiction* 2014 109(2): 250-9.

⁵⁸ Health Organization 2014a, *Community management of opioid overdose*, World Health Organization, Geneva. p.2.

⁵⁹ Strang J., Powis B., Best D., Vingoe L., Griffiths P., Taylor C. et al. Preventing opiate overdose fatalities with take-home naloxone: pre-launch study of possible impact and acceptability. *Addiction* 1999; 94: 199– 204.

NALOXONE TRAINING PROGRAM FOR FAMILIES AND CARERS (ENGLAND) - NATIONAL TREATMENT AGENCY FOR SUBSTANCE MISUSE (NTA)

The National Treatment Agency for Substance Misuse (NTA) launched an overdose and naloxone training program for family and carers of opiate users in 2009. The program operated across 16 sites in England from July 2009 to February 2010. At these 16 sites, 495 carers were trained to respond to an overdose using basic life support techniques. Those at 15 sites were also trained to administer naloxone. Participants were recruited in a variety of settings such as inpatient detox and prisons (during visits to inmates). At least one other study has recruited family members from support groups.⁶⁰

Several sites trained pairs of mutual carers (partners, close friends, or housemates), who both received a naloxone supply. Some were former service users no longer at risk of overdose themselves, but who cared for somebody at risk. The NTA evaluated the results of the carers' questionnaires and talked to the pilot leads and carers who went through the training.

Main findings include:

- The program demonstrates a strong need for THN training amongst family members of at-risk opioid users.
- It was more difficult to recruit carers for training than expected
- Difficulty with engaging carers of those leaving detox – perhaps due to stigma, and family members unaware of the user's drug use.
- Some prisoners and family members were concerned the training implied they were going to use drugs when they left prison. However, THN training among carers was successfully promoted as post-prison recovery in terms of a potential, but not inevitable outcome.
- The program created better contact between users and services, and better dialogue between users and carers.
- Out of 20 overdoses witnessed by participants during the study period, naloxone was administered 18 times. 'Basic life support' was applied in two cases. All people who overdosed survived.

The evaluation concluded that:

⁶⁰ Bagley, S, Peterson, J, Cheng, DM, Jose, C, O'Connor, PG & Walley, AY 2015, 'Overdose education and naloxone rescue kits for family members of opioid users: characteristics, motivations and naloxone use', in *Annual Meeting of the College on Problems of Drug Dependence*, San Juan, Puerto Rico, 14-19 June, published in *Drug and Alcohol Dependence*.

1. training could be adequately conducted in small groups, one-on-one and in participant homes;
2. training ought to be adapted to cater for different levels of familiarity with drugs and drug use, and to allow extra time for feelings/concerns to be discussed;
3. follow-ups and maintained contact with participants could strengthen and reinforce training.

Points to consider for future training:

- Training carers in small groups, one-to-one, or in their homes, may be appropriate.
- It may be helpful to adapt the training to the audience to cater for things such as: familiarity with drugs and needles; lived experience; time available for training; extra time for those who have found the training distressing, so they can talk through their feelings/concerns; enhance training with CPR and more advanced first aid if possible.
- Follow up: contact maintained after training, and six-month refresher courses were ideas communicated by carers. Sharing feelings, and hearing stories of naloxone administration were thought to be valuable.

Reference:

National Treatment Agency for Substance Misuse (2011), *The NTA overdose and naloxone training program for families and carers*, National Treatment Agency for Substance Misuse, London.

LEARN TO COPE [LTC] AND THE NOMAD (NOT ONE MORE ANONYMOUS DEATH) PROJECT, STATEWIDE, MASSACHUSETTS

COLLABORATION BETWEEN PARENTS AND A HARM REDUCTION PROGRAM

Learn to Cope (LTC) is a support group for parents and family members dealing with a loved one addicted to heroin, Oxycontin® and other drugs. A small group of parents affected by drug use established the group in 2004 in Massachusetts. The group started as a single, peer-to-peer support group and has grown nationally to nearly 3,000 members. While the cornerstone of LTC remains the weekly support meetings, the organisation has become a national model for addiction treatment and prevention programming. LTC also maintains a private online message board for parents and other family members, along with a resource guide and other information about substance use. The message board can be accessed at: <http://www.learn2cope.org>

How the collaboration evolved:

In 2005, outreach workers from a local needle exchange program attended a community forum about opiate use in a Boston suburb, where they heard Joanne Peterson, LTC founder, speak about their work. A longstanding collaboration began soon after this meeting.

The harm reduction program; Healthy Streets (part of now Northeast Behavioral Health), provided overdose prevention and naloxone distribution as part of their Not One More Anonymous Death (NOMAD) project. NOMAD workers first offered support to Learn to Cope families around substance abuse as well as help getting loved ones into treatment programs. As the relationship between the harm reduction program and LTC grew, they began to provide more services and education to the parents' group. Over recent years NOMAD/Healthy Streets has collaborated with the LTC family groups in the following ways:

- Providing education on: hepatitis C transmission, prevention and treatment; accessing substance abuse treatment and the realities of the process as a non-using family member and; recognising substance use;
- Providing naloxone training and enrolment at LTC support group meetings;
- Trained 12 parents from across Eastern MA to become approved opioid overdose trainers. They have since begun distributing naloxone in their respective groups;
- Two LTC group members presented at the "Youth At Risk" conference about working with parents of drug users;
- Providing technical assistance to families who were in LTC but still lost their loved one to a fatal overdose start their own support group called GRASP North Shore. Currently, staff meets to provide TA every three months or as needed via email and phone.
- Worked for six years with LTC on the Lynn, MA Overdose Vigil. Several parents have spoken and they also conduct outreach for the event.

Critical points about the program's success:

The parents' group never asked the harm reduction programs to hold back any information from families, no matter how uncomfortable it was for some to hear. Harm reduction programs, like needle exchange, can be difficult for some parents to accept at first, but with time and respectfully delivered information, many parents came to accept and even advocate for harm reduction programs.

The position was taken that families no longer need palatable information; they need the truth even if it is uncomfortable for some to hear. The partnership allowed for a lot to be shared, including “the realities of drug use that families are generally shielded from allowing them to have a full spectrum of accurate and useful information. Families often at times will call the program and ask us questions about treatment, come to the program with their loved ones to access treatment or work with us while a loved one is incarcerated to secure treatment upon their release.”

Some parents struggle with the harm prevention concepts, especially around needle exchange and safer drug use information. However, this collaboration shows that parents can be extremely supportive of overdose prevention efforts and naloxone distribution. A finding from the program is that when harm reduction programs work with families, the information and approach delivered to their audience must be tailored to be sensitive to parents’ needs. For example, overdose prevention training usually focuses on overdose risk factors, signs and symptoms, recognising overdose and responding, including rescue breathing and naloxone administration.

Reference:

Wheeler, E, Burk, K, McQuie & Stancliff, S 2012, *Guide to developing and managing overdose prevention and take-home naloxone projects*, Harm Reduction Coalition, New York, pp. 36-37.

MARYLAND, USA– COMMUNITY BASED OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION (OEND) PROGRAM

Baltimore Student Harm Reduction Coalition’s (BSHRC) Overdose Education and Naloxone Distribution (OEND) program provides free opioid overdose response training to potential witnesses (bystanders) of opioid-related overdose in Maryland. Since 2014, BSHRC has trained over 300 people in Baltimore city and in three Maryland counties. The program was inspired by the 2014 laws that allowed ‘third-party prescription’ of naloxone, provided they undertake relevant training.

The evaluation demonstrated that there was a significant demand for THN amongst friends and family of those at-risk of opioid overdose, with 72 per cent of the program attendees (n=263) fitting this category. It was noted that the introduction of third-party prescription significantly strengthened the existing ‘Good Samaritan’ laws in enabling greater access and distribution of naloxone into the community. Like the NTA study outlined above, this study found differences in THN training to concerned family and friends – rather than at-risk people themselves – including

differing knowledge of illicit substances, addressing the impact of the training beyond simply the administration of naloxone, and allowing space for discussion relating to experiences of witnessing an overdose. In an eight-month pilot period, 250 free naloxone kits were distributed, and three overdose reversals were reported to BSHRC.

Reference:

Lewis, D.A., Park, J.N., Vail, L. et al, Evaluation of the Overdose Education and Naloxone Distribution Program of the Baltimore Student Harm Reduction Coalition. *Am J Public Health*. 2016; 106: 1243–1246.

RESIDENTIAL CARE SETTINGS

OPIOID OVERDOSE PREVENTION IN A RESIDENTIAL CARE SETTING: NALOXONE EDUCATION AND DISTRIBUTION

One Colorado, USA based study examined the outcomes of a take-home naloxone program run through a residential treatment facility in which patients were educated in THN alongside their friends and/or family members. This program recognises that despite the success of opioid overdose prevention programs utilising naloxone, residential substance abuse treatment centres often emphasise abstinence-based care for those suffering from addiction and do not adopt harm reduction approaches such as naloxone education and distribution.

Opioid-dependent individuals participating and leaving residential treatment settings are vulnerable to overdose, particularly if they are not prescribed pharmacotherapy for their opioid dependence upon discharge. The program also recognises that family members are often overlooked by opioid overdose prevention programs.

Opioid dependent inpatients (n=47) along with their family members received overdose prevention training consistent with guidelines established by the Harm Reduction Coalition *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects* and SAMHSA's *Opioid Overdose Prevention Toolkit*.⁶¹

Patient family members were queried regarding their awareness of past opioid overdose by the patient. A pre- and post-training questionnaire based assessing ability to recognise overdose, fear of

⁶¹ SAMHSA (Substance abuse and Mental Health Service Administration) is a branch of the U.S. Department of Health and Human Services.

overdose, comfort in assisting with overdose, perception of life-threatening nature of addiction, and the value of overdose management was administered. A statistically significant improvement in overdose recognition and confidence to respond was found among participants (there was insufficient data to comment on overdose reversals, with only one reported use of the naloxone kit).

Reference:

Pade P, Fehling P, Collins S et al (2017): Opioid overdose prevention in a residential care setting: Naloxone education and distribution, *Substance Abuse*, Vol 38 (1)

PROJECT LAZARUS MODEL

Project Lazarus, established in 2007, is a community-based overdose prevention program in Wilkes County, Western North Carolina, USA. The non-profit organisation works to build coalitions to be effective in combating the overdose epidemic. The program focused on increasing access to naloxone for prescription opioid users. It is a public health model based on two principles;

1. Overdose deaths are preventable, and
2. All communities are responsible for their own health.

The program was developed in response to the high rate of overdose in Wilkes County, due almost exclusively to prescription opioid pain relievers (including fentanyl, hydrocodone, methadone, and oxycodone). Earlier data had shown that 80 per cent of overdose decedents did have a prescription for the medication that they died from in the months prior to death. This suggested that a prevention intervention located in medical practice could address a missed opportunity.

Naloxone distribution is enhanced by encouraging physicians to prescribe naloxone to their patients who are at highest risk of an overdose. Naloxone is also provided to people entering drug treatment and anyone voluntarily requesting naloxone. Naloxone is paid for through grants from industry.

How the model works:

The physician, who has been trained by Project Lazarus, identifies the patient as a naloxone priority patient, based on set criteria for overdose risk. When patients agree to participate in Project Lazarus, they watch a 20-minute DVD in the physician's office. The video covers patient responsibilities in pain management, storage, and disposal of opioid medications, recognising and responding to an opioid overdose, and options for substance abuse treatment. Project Lazarus participants then go to a pre-arranged community pharmacy and pick up a free naloxone kit.



The model, represented above, consists of a range of components:

- [“Community Education](#) -Improve the public's capacity to recognize and avoid the dangers of misuse/abuse of prescription opioids.
- [Provider Education](#) - Support screening and appropriate treatment for mental illness, addiction, and pain.
- [Hospital ED Policies](#) -Encourage safe prescribing of controlled substances and provide meaningful referrals for chronic pain and addiction.
- [Diversion Control](#) -Reduce the presence of unused medicines in society.
- [Pain Patient Support](#) to help patients and caregivers manage chronic pain.
- [Harm Reduction](#) to help prevent opioid overdose deaths with the antidote naloxone.
- [Addiction Treatment](#) to help find effective treatment for those ready to enter recovery.”

Results from the program show overdose death rate falling 42 per cent from 2009 to 2010 and substance abuse related emergency department admissions dropping by 15 per cent from 2008 to 2010. In 2010, 10 per cent of fatal overdoses were the result of a prescription for an opioid analgesic from a Wilkes County prescriber, down from 82 per cent in 2008. “The findings show that after one-

on-one education sessions, prescribers increased their use of pain agreements and utilization of the prescription monitoring program (in Wilkes, approximately 70 per cent of eligible physicians are signed up, versus 20 per cent for the rest of the state). Just as importantly, prescribers reported feeling more secure treating pain and increasing doses as needed; patients responded feeling legitimized in having their pain needs addressed and found it worthwhile having explicit rules within which to seek treatment.”

References:

1. Kuehn B, Back from the Brink: Group Urge Wide Use of Opioid Antidote to Avert Overdose, *JAMA* 2014; 311 (6) 560-561
2. <https://www.projectlazarus.org/>

4. PEERS, PEER-LED PROGRAMS AND HARM REDUCTION

[T]here is no doubt of the relevance of consumer participation in AOD services, and the benefits of utilising peer support and mutual aid as a positive tool in service delivery.⁶²

WHAT MAKES A PEER AND WHO IS A PEER?

From consulting with key stakeholders about who is a peer and from the broad range of definitions found in the literature, it is evident that there is no one definition or position. To be a peer or to recognise someone as a peer is about sharing something with that person apart from something generic like age or sex. While a peer is someone who shares a similar lived experience with someone, there is considerable tension within the sector over the validity and worth of someone who currently uses versus someone who has used drugs in the past.

From reviewing a wide range of models and interventions across harm reduction, mental health and recovery services (refer to terms of reference), it is evident that the question of who is a peer raises considerable passion and brings in to question issues of legitimacy and who is able to speak for whom. As one NSP worker commented: “I struggle with the peer definition. No one has identified what a peer-based service is to me.” For some it is enough to say that a peer is someone who shares a similar lived experience.

Being accepted as a peer is a social process of identifying, and being identified, as part of a group, network, community or culture. It is not a decision that can be made by others outside the process.⁶³

Undoubtedly the peer-to-peer relationship is built upon common knowledge and shared experiences.⁶⁴

[W]hat is of greatest importance in making peers is that those involved in the process regard one another as peers.⁶⁵

⁶² Association of Participating Service Users (APSU), 2012, The Peer Model Manual-Consumer Participation in Action, Victoria, Australia

⁶³ Madden, Byrne and Bath, 2002 cited in AIVL, 2006, A Framework for Peer Education by Drug User Organisations page 25

⁶⁴ Association of Participating Service Users (APSU), 2012, The Peer Model Manual-Consumer Participation in Action, Victoria, Australia p. 6.

⁶⁵ Milin, A, 2002 cited in Madden et al AVIL, 2006 Ibid.

SAMHSA (Substance Abuse and Mental Health Services Administration) defines the role of the peer support worker:

The role of the peer support worker has been defined as “offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations.” Peer support has been described as “a system of giving and receiving help” based on key principles that include “shared responsibility, and mutual agreement of what is helpful.”⁶⁶

PEER-BASED STRATEGIES

Since *peers* were first recognised as having a critical role in preventing the spread of blood borne viruses (BBVs) - during the HIV/AIDS crisis of the 1980s and 1990s - the focus on expanding peer roles, peer-based education and considering how they can be best utilised has grown. This has resulted in a shift away from valuing peers predominantly for their cultural competencies to engage with marginalised groups, and their ability to reach ‘hidden’ and therefore difficult to reach populations, towards an additional focus on meaningful engagements^{67,68,69}, peer integration into harm reduction (and other) workforces^{70,71,72,73}, and efforts to reduce institutionalised stigma and discrimination so that peers can more effectively carry out their duties.^{74,75}

⁶⁶ https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tac/core-competencies.pdf

⁶⁷ Greer, AM, Luchenski, SA, Amlani, AA, Lacroix, K, Burmeister, C & Buxton, JA 2016, ‘Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada’, *BMC Public Health*, vol. 16, no. 452, pp. 1-9.

⁶⁸ Toronto Harm Reduction Taskforce 2013, *Information guide for peer workers and agencies*, 2nd edn, Toronto Harm Reduction Taskforce, Toronto.

⁶⁹ Penn, R, Muckath, S, Henschell, C, Andrews, J, Danis, C, Thorpe, M, Thompson, M, Gao, Y, Miller, C & Strike, C 2011, *Shifting roles: peer harm reduction work at Regent Park Community Health Centre*, Centre for Addiction and Mental Health, Toronto.

⁷⁰ Department of Behavioural Health and Intellectual Disability Services 2017, *Peer support toolkit*, Department of Behavioural Health and Intellectual Disability Services, Philadelphia, accessed 16 March 2017, <<http://dbhids.org/about/organization/strategic-planning-division/peer-culture-and-community-inclusion-unit/peer-support-toolkit/>>.

⁷¹ International HIV/AIDS Alliance 2015, *Good practice guide for employing people who use drugs*, International HIV/AIDS Alliance, accessed 16 March 2017, <https://www.aidsalliance.org/assets/000/001/840/Employing_FINAL_original.pdf?1445009816>.

⁷² Jürgens, R 2008, “Nothing about us without us” – Greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative. *International edition*, Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute, Toronto.

⁷³ Balian, R & White, C 2010, *Harm reduction at work: a guide for organizations employing people who use drugs*, Open Society Foundations, New York.

⁷⁴ Department of Behavioural Health and Intellectual Disability Services 2017, *Peer support toolkit*, Department of Behavioural Health and Intellectual Disability Services, Philadelphia, accessed 16 March 2017, <<http://dbhids.org/about/organization/strategic-planning-division/peer-culture-and-community-inclusion-unit/peer-support-toolkit/>>.

⁷⁵ International HIV/AIDS Alliance 2015, *Good practice guide for employing people who use drugs*, International HIV/AIDS Alliance, accessed 16 March 2017, <https://www.aidsalliance.org/assets/000/001/840/Employing_FINAL_original.pdf?1445009816>

Evidence for the effectiveness of peer-based programs:

Many of the reviewed studies referenced in this section found that the involvement of peers was a key factor for the success of a particular project and/or strategy: whether it be in terms of reducing risk behaviours for the spread of BBV;^{76,77,78} increasing community support for harm reduction efforts;^{79,80} increases in overdose knowledge;⁸¹ or the success of harm reduction initiatives generally.^{82,83} However these findings were not based on randomised trials. While much of the literature proceeds as if the effectiveness or benefits of peer-based strategies is a given, there have been some notable attempts to demonstrate this effectiveness.

One randomised-controlled trial conducted across five cities in the US in 2002-2004 focused on peer education.⁸⁴ Participants were trained over six sessions in risk reduction for spreading BBV and in peer education skills. Six months after the intervention there was a 29 per cent decline in overall injection risk behaviours compared to the control group, and a 76 per cent decline compared to baseline.

A systematic review was conducted by Sacks-Davis and colleagues to determine whether behavioural interventions are effective in preventing transmission of hepatitis C virus amongst people who inject drugs.⁸⁵ The behavioural interventions were all non-pharmacological with the aim to change individual behaviours. Six trials evaluating peer-education training and counselling interventions were included in the review. Amongst the three studies which measured the impact of the intervention on HCV incidence, none found a statistically significant difference between

⁷⁶ Jain, B., Krishnan, S., Ramesh, S., et al., N 2014, 'Effect of peer-led outreach activities on injecting risk behavior among male drug users in Haryana, India, *Harm Reduction Journal*, vol. 11, no. 3, pp. 1-6.

⁷⁷ Wang, K., Longfield, K., Modi, S., et al. 2014, 'Do community-based strategies reduce HIV risk among people who inject drugs in China? A quasi-experimental study in Yunnan and Guangxi provinces', *Harm Reduction Journal*, vol. 11, no. 15, pp. 1-9.

⁷⁸ Hayashi, K, Wood, E, Wiebe, L, et al. 2010, 'An external evaluation of a peer-run outreach-based syringe exchange in Vancouver, Canada', *International Journal of Drug Policy*, vol. 25, no. 5, pp. 418-421.

⁷⁹ Ngo, AD, Schmich, L, Higgs, P et al. 2009, 'Qualitative evaluation of a peer-based needle syringe programme in Vietnam', *International Journal of Drug Policy*, vol. 20, no. 2, pp. 179-182.

⁸⁰ Eurasian Harm Reduction Network 2016, *Great success of small grants*, Eurasian Harm Reduction Network, Vilnius.

⁸¹ Winhusen, T, Theobald, J, Lewis, D, et al. 2016, 'Development and initial testing of a tailored telephone intervention delivered by peers to prevent recurring opioid-overdoses (TTIP-PRO)', *Health Education Research*, vol. 31, no. 2, pp. 146-160.

⁸² Moorthi, G 2014, 'Models, experts and mutants: exploring the relationships between peer educators and injecting drug user clients, in Delhi's harm reduction programs', *Qualitative Social Work*, vol. 13, no. 1, pp. 69-84.

⁸³ Janssen, PA, Gibson, K, Bowen, R, et al. 2009, 'Peer support using a mobile access van promotes safety and harm reduction strategies among sex trade workers in Vancouver's downtown eastside', *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, vol. 86, no. 5, pp. 804-809.

⁸⁴ Garfein, RS, Golub, ET, Greenberg, AE, et al. 2007, 'A peer-education intervention to reduce injection risk behaviours for HIV and hepatitis C virus infection in young injection drug users', *AIDS*, vol. 21, no. 13, pp. 1923-1932.

⁸⁵ Sacks-Davis, R., Horyniak, D., Grebely, J., et al (2012) Behavioural interventions for preventing hepatitis C infection in people who inject drugs: A global systematic review, *International Journal of Drug Policy*, vol 23, no. 3 pp. 176-184.

intervention and control groups. The authors concluded that it is unlikely that behavioural interventions can have a considerable effect on HCV transmission and likely that multi-component interventions are required.

A WHO study that reviewed 40 published studies on ‘community-based outreach’ (not peer) applied the Hills Criteria for Causation to three questions: (1) Is outreach an effective strategy for reaching hard-to-reach, hidden IDU populations and providing the means for changing behaviour? (2) Do a significant proportion of IDUs receiving outreach-based interventions reduce their HIV risk behaviours—drug using, injecting equipment use and sexual —and adopt safer behaviours? (3) Are changes in behaviours associated with lower rates of HIV infection among IDUs? Evidence for all three questions was deemed to be strong – that is, ‘these [positive] findings have been consistently reported by different investigators, in different places, under different circumstances and at different times.’⁸⁶

PEER ROLES IN HARM REDUCTION

There is a great breadth and diversity to the roles that peers can take within harm reduction programs and strategies. A systematic review of academic and grey literature published between 1987 and 2014, published in 2015 by Marshall et al.,⁸⁷ identified 36 distinct roles that peers fulfil in harm reduction settings, grouping those roles into five categories. These are detailed in Figure 1 below.

⁸⁶ Needle, RH, Burrows, D, Friedman, SR, et al. 2005, ‘Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users’, *International Journal of Drug Policy*, vol. 16S, pp. S45-S57, p.S54

⁸⁷ Marshall, Z., Dechman, M., Minichiello, A., et al. 2015, ‘Peering into the literature: a systematic review of the roles of people who inject drugs in harm reduction initiatives’, *Drug and Alcohol Dependence*, vol. 151, pp. 1-14.

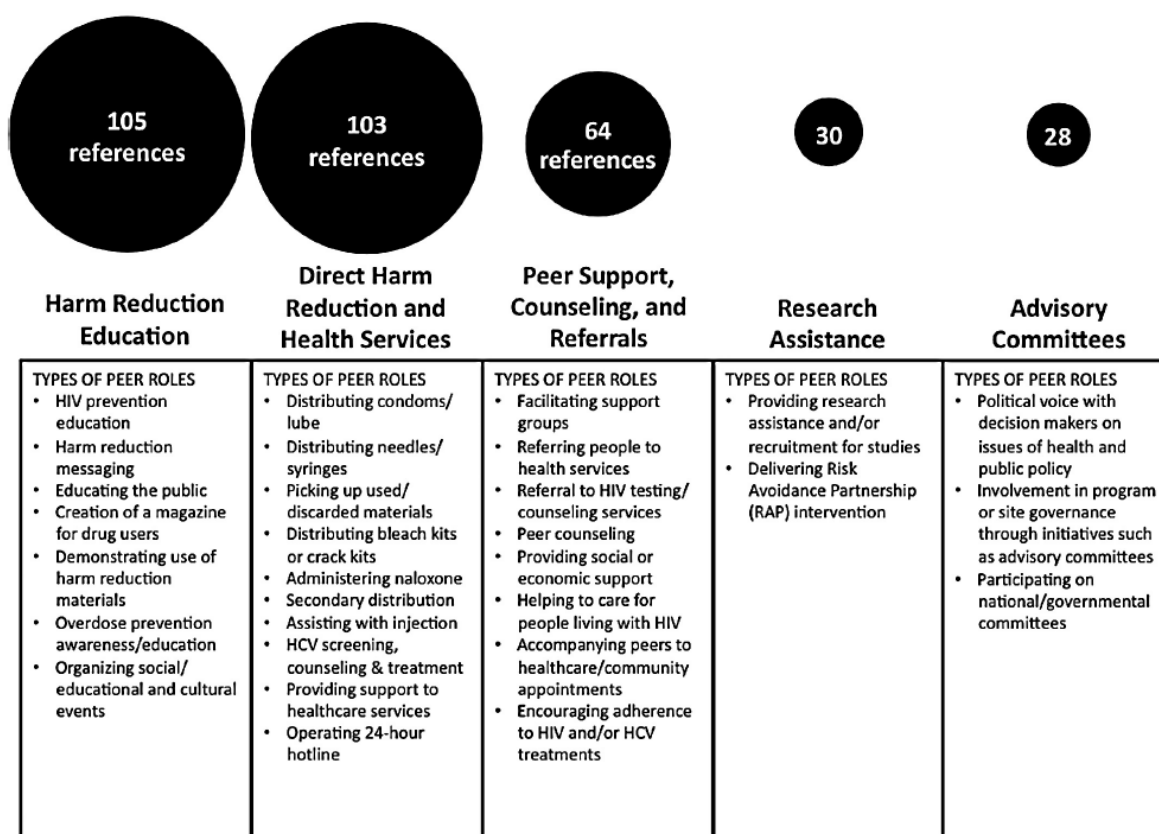


Figure 1 – Categories of peer roles in harm reduction initiatives, reproduced from Marshall et al. (2015, p. 5).

To these findings we can add: the role of a ‘peer greeter’ who keeps clients engaged and fosters a welcoming environment as other reception staff may be too busy;⁸⁸ peer-delivered rapid HIV testing with pre- and post-test counselling;⁸⁹ staffing a mobile access van which, in addition to providing standard harm reduction interventions, enabled sex workers (including those who inject drugs) to use this service as a shelter for safety and respite from the precariousness of street life, and;⁹⁰ providing knowledge of and responses to new drug trends and emerging risk behaviour.^{91,92}

⁸⁸ Department of Behavioural Health and Intellectual Disability Services 2017, Peer support toolkit, Department of Behavioural Health and Intellectual Disability Services, Philadelphia, accessed 16 March 2017, <http://dbhids.org/about/organization/strategic-planning-division/peer-culture-and-community-inclusion-unit/peer-support-toolkit/>

⁸⁹ Ti, L., Hayashi, K., Kaplan, K., et al. 2013, ‘Willingness to access peer-delivered HIV testing and counseling among people who inject drugs in Bangkok, Thailand’, *Journal of Community Health*, vol. 38, no. 3, pp. 427-433.

⁹⁰ Janssen, P., Gibson, K., Bowen, R., et al 2009, ‘Peer support using a mobile access van promotes safety and harm reduction strategies among sex trade workers in Vancouver’s downtown eastside’, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, vol. 86, no. 5, pp. 804-809.

⁹¹ International HIV/AIDS Alliance 2015, Good practice guide for employing people who use drugs, International HIV/AIDS Alliance, accessed 16 March 2017, <https://www.aidsalliance.org/assets/000/001/840/Employing_FINAL_original.pdf?1445009816>.

⁹² Balian, R & White, C 2010, Harm reduction at work: a guide for organizations employing people who use drugs, Open Society Foundations, New York.

An alternative way to categorise the diversity of peer roles is by considering degrees of involvement. Through the work of the International HIV/AIDS Alliance, the involvement of people who use drugs in harm reduction has been conceptualised as a pyramid that moves from the least involved level as a *target audience*, to marginally involved *contributors*, to sharing their views as *speakers*, and on to more actively involved roles as *implementers*, *experts*, and ultimately as *decision makers* (see Figure 2).^{93,94}

A pyramid of involvement*

This pyramid models increasing levels of drug user involvement, with the highest level representing complete application of the greater involvement principle.

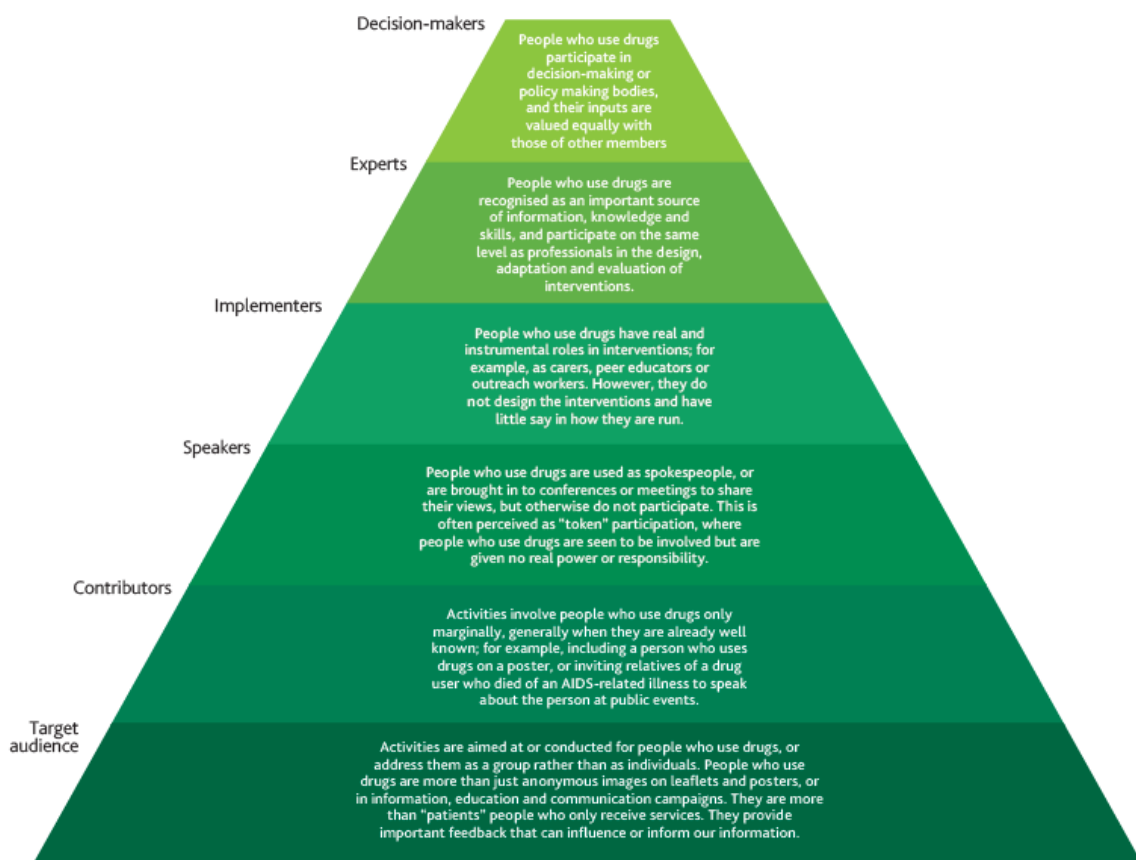


Figure 2 – A pyramid of peer involvement, reproduced from International HIV/AIDS Alliance (2015, p. 7).

⁹³ International HIV/AIDS Alliance 2015, *Good practice guide for employing people who use drugs*, International HIV/AIDS Alliance, accessed 16 March 2017, <https://www.aidsalliance.org/assets/000/001/840/Employing_FINAL_original.pdf?1445009816>.

⁹⁴ Jürgens, R 2008, "Nothing about us without us" – *Greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative*. International edition, Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute, Toronto.

The following examples each involve peers – including people who use drugs and people with lived experience - and give some insight into the value of their involvement:

5. The Exponents' ARRIVE program demonstrates the value of peers (people in recovery and those living with HIV) in leading this program in both design and delivery.
6. The drug alerts and communicating drug quality among peer networks research in British Columbia, Canada demonstrates the importance of involving peers in designing communications and providing opportunities for feedback in order to improve strategies for producing and disseminating information on local drug trends.
7. A speakers' bureau provides a platform for people with lived experience of drug issues to share their stories with appropriate target audiences, with the aim of raising awareness and reducing stigma.
8. Outlining the development of a *safer crack pipe kit* in Toronto, Canada provides a case study for how a local peer-run harm reduction program identified an emergent public health issue and successfully overcame various challenges to address it.

EXPONENTS ARRIVE PROGRAM:

The Exponents' ARRIVE program is the longest running harm reduction program in the United States and was established in response to the issue of HIV/AIDS in the injecting drug-using community. One of the driving principles of the program, and a key reason for its success, is how the initiative responds to the changing needs of the community. The program is creative, adaptable and inclusive.

Exponents' services range from working with people who currently use drugs, high school equivalency classes, and professional trainings helping people to re-enter the workforce. Their work is premised on the idea that offering a range of beneficial social services, even if they do not entirely relate to drug treatment, and supporting multiple visions of recovery works better than using one rigid approach. An article from *Time* magazine writes about one past participant's reason for attending the program:

[He] didn't come to Exponents for treatment; he came because he wanted to improve his health.⁹⁵

ARRIVE [itself] is an eight-week program, delivered through 24 2.5-hour psycho-educational and health and wellness sessions. The program operates five times a year and was originally established to engage with recently released prisoners known to have a history of injecting. The program has since broadened its scope to include other cohorts.

⁹⁵ <http://healthland.time.com/2011/09/30/viewpoint-teaching-recovery-rather-than-treating-addiction/>

A core element of the program is the ongoing engagement of each participant at multiple levels, including: psycho-education and health and wellness information disseminated in large group settings with smaller breakout discussion groups and support groups for at-risk and HIV+ participants and individual counselling. The program's primary purpose is to teach self-management skills to address chronic health conditions (such as addiction, HIV or HCV) and to reduce levels of infection/transmission risk to both themselves and their sexual and drug-sharing partners. Through personal investment in the process, participants enhance their self-esteem.

A large number of participants have criminal justice histories and have encountered long periods of homelessness. Both active and recovering substance users are welcomed into the program. To date there are 10,500 graduates with a 75 per cent graduation rate. All components of the course are facilitated by peers, including past graduates, recovering individuals, persons with compromised immune systems and formerly incarcerated people.

The program draws on a range of evidence-based practices:

1. Psycho-education (*proven highly successful working with individuals with mental illness*) – provides insight into motivational circumstances/situations that prompt individuals to 'self-medicate'
2. Peer Support/Role Modeling – provides ongoing inspiration that participants can transform their lives through the adoption of new, healthier behaviours. Due to the daunting challenges faced by participants, it is considered important for the program to have role models. The program is led by peers, people in recovery and those living with HIV.
3. Creation of Community – breaks the destructive cycle of isolation and depression often brought on by sustained drug/alcohol use; (re)ignites an acknowledgement of the individual's spiritual self
4. Advocacy on Behalf of Participants – relays genuineness, concern for overall well-being, and continued success.
5. Social Learning Approach - close contact (community, small team breakdowns), imitation of superiors (peer engagement), understanding of concepts (psycho-education), role model behaviour. ...where positive, healthy behaviour is practiced by staff and peers.

The focus of the program is on peoples' strengths, as Howard Josepher, the founder of the program, states: "We wanted them to realize what their minds could accomplish if they focused on something

positive. We developed a client-centered approach, supporting multiple recovery pathways while maximizing the importance of good health and well-being.”

The program was externally evaluated in 1991 and 2009. Findings from these evaluations show that participants are more likely to be tested for HIV, less likely to have been arrested, and possessed higher levels of employment during the follow-up period. The 2009 evaluation identified that 71 per cent of current or former drug users reported an increased ability to deal with stigma, 41 per cent increase in self-efficacy related to emotional response to HIV status 30 per cent increase related to HIV disclosure self-efficacy, and 37 per cent increase in HIV treatment adherence.

Reference:

Joseph, H., From Harm Reduction to Recovery: Exponents, *Recovery to practice, resources for behavioural Health Professionals*, Vol, 3, Issue 12, 2012.

http://www.atr.samhsa.gov/Resources/wh/2012/2012_03_29/wh_2012_03_29.html

DRUG ALERTS AND COMMUNICATING DRUG QUALITY AMONG PEER NETWORKS

This study, conducted in British Columbia, Canada, was carried out in response to the lack of published literature that examines the ways that people who use drugs engage with drug alerts (i.e. communications designed to inform drug using cohorts on waves of contaminated or particularly potent drug supplies in a local area), and the general lack of knowledge in terms of the most effective strategies in order to make these alerts. The research sought to better understand: (1) how illicit drug users went about assessing drug quality and associated attempts to reduce the harms of impurities, and; (2) user experiences of drug alerts and their thoughts on how they could be more efficient.

The cohort of participants typically viewed the drug using scene (in downtown east side of Vancouver) as a ‘close-knit community’ where people actively cared for one another. Therefore, when people who use drugs became aware of poor quality or adulterated drugs they typically communicated this by word of mouth among their networks. Generally, participants felt that service providers were not relevant for these issues and did not share information about the state of currently available drugs with them. While most did not consider service providers as a key place to obtain information on drug purity/quality, many participants did appreciate these alerts and reported changing their behaviour accordingly.

Some practical guidelines were communicated by participants:

- (1) As the most timely information about drug quality came from the users themselves, it was agreed that partnerships between peers and service providers could help with drug alerts. This could broaden the reach of peer generated information on drug quality and prevent the spread of less reliable or unreliable information.
- (2) Alerts should be brief and communicated in clear, simple language. Examples of words to be used were 'warning', 'toxic', 'dangerous' or 'lethal'. Words relating to drug strength, such as 'potent', should be avoided when communicating bad batches of drugs as this could be misconstrued as the drugs being of higher quality – and therefore people may seek these drugs out rather than avoid them.
- (3) Participants felt that drug alerts were usually communicated after the bad supply had already been and gone. To avoid this, alerts should be put out after the very first reported overdose has occurred. As one participant said: "Don't wait for the third person to die. If somebody O.D.'s off of it, find out why and which type of dope it was and then report it. Don't wait for those one or two more to go 'cause that's not the way it should be done" (p. 1254).
- (4) While the exact mode of communicating drug alerts was not seen to be of particular importance (e.g. poster, television, newspaper, internet), it was seen to be important that they be 'accessible, highly visible, denoted by color, and date-stamped'. Therefore, while posters in harm reduction services might be useful for some users, others who do not access these services could be better informed if such posters were also put up in local alley ways. Further, posters (for example) should not be left up too long, as they lose their relevance and people begin to ignore them after a while.
- (5) Greater details in overdose deaths were needed. These should be detailed and communicate what was going on in the event of an overdose, rather than simply focusing on the drug. The 'suspected route of administration' was one such detail.

Reference:

Soukup-Baljak, Y, Greer, AM, Amlani, A, Sampson, O & Buxton, JA 2015, 'Drug quality assessment practices and communication of drug alerts among people who use drugs', *International Journal of Drug Policy*, vol. 26, no. 12, pp. 1251-1257.

SPEAKER BUREAU – RAISING AWARENESS AND REDUCING STIGMA

A speaker's bureau allows for people with personal experiences of drug use to share their unique stories. Their aim is to increase empathy and raise awareness around drug use issues including experiences of recovery. A range of platforms have evolved to facilitate connecting the right speaker for the audience, the logistics for which are usually dealt with by an organisation.

For example, the Speaker Bureau run by The Association of Participating Service Users (APSU) facilitates presentations from people with a personal experience of addiction (with or without mental health issues), thereby providing opportunities to share an experiential perspective on alcohol and other drug issues. Family members affected by a loved one's AOD issues can also be members of the Speaker Bureau. The program has operated since 2001, expanding in the past three years with greater attention given to building a structure to support speakers, including screening of speakers, matching the speaker with audience requirements, and training speakers so they know and are comfortable with their audience and are equipped to share their story. Members of the Speaker Bureau participate in forums and meetings and also act as consumer representatives. APSU maintains a database that includes speakers and meeting participants, their skills and interests. This information enables APSU workers to select the most appropriate speaker or 'meeting participant' for each occasion.

OverdoseFreePA Speaker's Bureau –Pennsylvania:

This program is part of Pennsylvania's Overdose Prevention Coalition, highlighted in section 1 (A Central Overdose Resource - overdosefreePA). The speakers within this bureau are nominated by the Single County Authority of each participating county. They have been nominated because of their expertise on topics related to overdose prevention, Substance Use Disorder treatment, recovery and other overdose-related topics.

Organisations interested in hosting a speaker are asked to browse the list of speakers under each participating OverdoseFreePA county. By clicking on the speaker's name a list of approved topics and contact information for each speaker is provided. Host organisations and speakers are responsible for scheduling and arranging each engagement. The topics covered are extensive, including the following:

Addiction as a Disease/Co-occurring Disorder Recovery/Co-dependency/Community Resources for Addiction/Current Trends/Ethics-Burnout/Family Dynamics/Harm Reduction Based Strategies/Implementing Naloxone Prescriptions/Living in Addiction/Living in Recovery/Medication Assisted Treatment/Medication Disposal Program/Opiate Safety: The Role of Naloxone/Overdose

Prevention/Overdose Prevention & Response with Naloxone/Overdose Prevention (Community Perspective)/Overdose Prevention (Courts)/Overdose Prevention (Educator Perspective)/Overdose Prevention (Faith-Based/Clergy Perspective)/Overdose Prevention (Healthcare Provider Perspective)/Overdose Prevention (Law Enforcement Perspective)/Overdose Prevention (Long Term Recovery)/Overdose Prevention (Recovery Perspective)/Peer Counselling/Person in Long-Term Recovery/Personal Experience/Prescription Drug Abuse/Prevention Programming and Participation/Project MEDS/Recovery Process/Recovery-Oriented System of Care/Statistics/Substance Use Treatment

Reference:

<http://www.overdosefreepa.pitt.edu/speakers-bureau/>

SAFER CRACK PIPE KIT: AN EXAMPLE OF HOW PEER-BASED HARM REDUCTION RESPONDS TO CHANGES IN DRUG USE CONSUMPTION (CANADA)

After finding out that a significant portion of local crack-cocaine users were smoking out of unsanitary, unsafe, make-shift equipment a local harm reduction co-ordinator set out to create a 'safer crack pipe kit'. With money from the program budget, she visited a local hardware store and worked with one of the staff members to find suitable materials for a pipe. This turned out to be stainless steel with non-toxic screens – all later confirmed to be non-hazardous via toxicology testing.

The design catered to the specific contexts and usage patterns of the users in that: (1) glass pipes were highly likely to break during the frequent travelling undergone by service users, as well during police 'harassment' which often involved the 'trashing' of people's belongings – metal would not; (2) unlike glass pipes, the stems would not get hot, and this would lessen the chances of burns; (3) the mouthpieces were coated in plastic and could be replaced, which lessened the chances of infections being passed between users if pipes were to be shared.

Production of the pipes had barely begun when the community health organisation that hosted the harm reduction program received some 'dubious' legal advice, leading to the project being cancelled. Determined to continue, the co-ordinator approached a local users' organisation who were happy to continue the work. It was at this stage that the full contents of the kit were determined. This included: a pipe with extra screens; a small zip lock bag to hold everything; a pamphlet with instructions on how to use the pipe, and safe smoking and other harm reduction information; sugarless gum to prevent jaw clenching and promote minor dental hygiene; lip balm to

reduce burns and cuts on mouth; packs of non-toxic matches; lube and condoms; vitamin C to use when breaking down crack for injection; and extra mouth-pieces for reducing communicable diseases when sharing pipes. 2500 kits were assembled in total.

It was considered important to get the word out about the program prior to distributing them, so a regular drop-in session run from a local church was used as a community event with food, live music and user organisation members sharing experiences of crack using. A press conference was tacked on to this event, which gained significant media attention, and those running the project also sought further interviews and television appearances to publicise the intervention. For further preparation, a lawyer was contacted to ensure that no laws were being broken, the police made public statements to the effect that they would not interfere with the project by confiscating the pipes, and the times and places for kit distribution were made generally known to users.

The kits were delivered via outreach by teams of two people from the drug user organisation. People were approached in the locations where they were thought likely to be such as parks, street corners, shelters and community service sites. The response was intensely positive. After two weeks, more than 500 kits were distributed and 254 surveys were completed. Other harm reduction services were approached to distribute the remaining (roughly 2000) kits, of which five agreed, and a day-long training workshop was organised for these groups.

Thought was also given to the expansion of the project, so that it would not become a 'once-off' or a 'band-aid' to a significant and widespread problem. The co-ordinator designed an oral survey, which was presented to the user organisation for feedback. The questions cover basic demographics, what materials are typically used by people to make crack pipes, their BBV status, whether they shared pipes, what harms (e.g. burns or cuts) had been sustained using make-shift pipes, and whether they shared pipes after sustaining these kinds of injuries.

The results were written up in a report. A meeting was called with Toronto's Department of Public Health and a committee formed to determine the way forward. A compromise was reached where the crack pipes would be made with Pyrex stems to reduce costs, and through a combination of Department funding and other unspecified funding, these kits were made continually available to users free of charge. Eight other Canadian cities have now adopted this intervention.

Reference:

Balian, R & White, C 2010, *Harm reduction at work: a guide for organizations employing people who use drugs*, Open Society Foundations, New York.

INTEGRATING PEER-BASED STRATEGIES INTO HARM REDUCTION ORGANISATIONS

One of the most fruitful topics addressed in the space of peer-based harm reduction in recent years has been the integration of peer workers into harm reduction organisations. What has in many past initiatives been viewed as a ‘cheap strategy’ and therefore often underfunded⁹⁶ is being increasingly perceived as integral to effective service provision.⁹⁷ This is part of a much wider movement in public health policy wherein the experiences, knowledge and perspectives of people who use, or have used, are valued and utilised in health services in order to reflect upon and improve the service.⁹⁸ In spite of this growing recognition, a lack of peer integration into harm reduction services – with many stakeholders reporting that peer-based initiatives are treated more like ‘add-on’ or ‘stand-alone’ programs – continues to be widely cited.⁹⁹ A key aim of this section is to outline ways in which peer integration can be improved/strengthened/developed, as well as the benefits of doing so and the kinds of challenges that are typically experienced.

Developing recovery capital through peer work:

Through better integration of peer strategies a culture that values peer work can be fostered that can assist in developing the *collective recovery capital* of communities and networks of people who use drugs.^{100,101} Recovery capital is the resources that people can use in order to address and perhaps overcome some of the adverse outcomes associated with drug use.¹⁰² More specifically, this is “an understanding of recovery that is aligned with harm reduction to describe a self-directed process that contributes to health and well-being, empowerment, and social inclusion”.¹⁰³

Drawing from a qualitative research project based in the Regent Park Community Health Centre’s (RPCHC) harm reduction program, in Toronto, Canada; Penn and colleagues, sought to investigate the relationship between reducing the threshold of entry-level peer work (to expand their peer

⁹⁶ Goren, N & Wright, K 2006, ‘Prevention research evaluation report no. 17: peer education as a drug prevention strategy’, in *Prevention Research Quarterly*, DrugInfo Clearinghouse, West Melbourne, pp. 3-20.

⁹⁷ Department of Behavioural Health and Intellectual Disability Services 2017, *Peer support toolkit*, Department of Behavioural Health and Intellectual Disability Services, Philadelphia, accessed 16 March 2017, <<http://dbhids.org/about/organization/strategic-planning-division/peer-culture-and-community-inclusion-unit/peer-support-toolkit/>>.

⁹⁸ Branfield, F, Beresford, P, Andrews, E., et al. 2006, *Making user involvement work: supporting service user networking and knowledge*, Joseph Rowntree Foundation, York.

⁹⁹ Mason, K 2006, *Best practices in harm reduction peer projects*, Street Health, Toronto.

¹⁰⁰ Balian, R & White, C 2010, *Harm reduction at work: a guide for organizations employing people who use drugs*, Open Society Foundations, New York.

¹⁰¹ Penn, R., Strike, C. & Mukkath, S., 2016, ‘Building recovery capital through peer harm reduction work’, *Drugs and Alcohol Today*, vol. 16, no. 1, pp. 84-94.

¹⁰² Ibid.

¹⁰³ Ibid, p. 84.

program) and the development of recovery capital in individual peers as well as collectively in local peer networks.¹⁰⁴

Across the different types of recovery capital under consideration – social, physical, human, cultural, and collective – they found that participants in their peer program developed this capital in the following ways:

- *Social recovery capital*: increased wellbeing through the support and company of increased relationships; increased use of health services (due to familiarity of workers and proximity to them); recovery capital increased through the development of obligations (and expectations) to others.
- *Physical recovery capital*: rewards, reimbursement or pay typically started low, but likewise there was little expected of peers at this level (simply attending was often sufficient in early stages), and this 'low threshold' facilitated the first transitions into this space; many staff members noted an increase in peers securing stable housing as they moved from lower threshold to more involved peer work, which was associated with greater overall levels of well-being and more controlled drug use.
- *Human recovery capital*: cyclical, in that the money earned and responsibilities taken helped to increase wellbeing, self-esteem and moderation in substance use; increased employability; abstinence not required, but many peers managed their use for functionality; reduced involvement in criminal justice system reported; many noted that large gaps in employment history, low levels of education (30 per cent not completed high school) and criminal records all reduced future employability in the face of aforementioned benefits.
- *Cultural capital*: some stated that their peer work could help them get 'clean' which would help them to live a more 'straight' life; some were concerned with the title of 'peer worker' and rather be considered as 'a normal kind of worker'
- *Collective recovery capital (recovery capital at the community level)*: having structured peer programs in place can facilitate recovery on a collective level, as it provides regular opportunities for increasing the kinds of capital stated above.

Reference:

Penn, R., Strike, C. & Mukkath, S. 2016, 'Building recovery capital through peer harm reduction work', *Drugs and Alcohol Today*, vol. 16, no. 1, pp. 84-94.

¹⁰⁴ Ibid.

Participation of peers in harm reduction program – Norway:

Like the above study on recovery capital, an ethnographic study of a HIV-focused peer harm reduction program in Norway, published in 2005 by Middelthon, found that participation had a stabilising effect on many peers.¹⁰⁵ This took the form of acquired housing, engagement in paid employment or study, a reduction in drug use and/or enrolment into treatment (often for the first time). It is important to note that (like the above study on Regent Park) a reduction or cessation of drug use was not part of the program. This project was run at seven sites in Norway, with one site engaging peers who were sex workers. The peers who were sex workers stated that they found it more difficult to ‘sell sex’ after their involvement in the harm reduction initiative as engaging in health promotion work within this space had given them a new perspective on their practices and the sex work scene itself and they had, thereafter, begun to see themselves differently.

In addition, the social workers involved in the program also reported that it was an overwhelmingly positive experience and was transformative in the sense that it: (1) challenged and changed their pre-existing views on people who use drugs; (2) helped them see the people involved as more than simply ‘determined by drugs’; (3) gave them an opportunity to learn from the people who used drugs, seeing their knowledge as ‘expert’ knowledge.

Example of an integrating model:

The literature shows growing support for broadening the scope of peer work to include low commitment, easy to engage with roles alongside more complex roles with greater levels of responsibility. Doing so caters for different individual needs, goals, capacities, and life situations.^{106,107,108}

This is most clearly outlined in the report for another research project by Regent Park Community Health Centre (RPCHC) in Toronto, Canada, conducted by Penn and colleagues, titled; *Shifting roles:*

¹⁰⁵ Middelthon, A. 2005, ‘A room for reflection: self-observation and transformation in participatory HIV prevention work’, *Medical Anthropology Quarterly*, vol. 19, no. 4, pp. 419-436.

¹⁰⁶ Winkelstein, E. 2011, ‘User-to-user: peer-delivered syringe exchange in New York City’, Harm Reduction Coalition, New York.

¹⁰⁷ Penn, RA, Strike, C & Mukkath, S 2016, ‘Building recovery capital through peer harm reduction work’, *Drugs and Alcohol Today*, vol. 16, no. 1, pp. 84-94.

¹⁰⁸ See also: Penn, R., Mukkath, S., Henschell, C, et al. 2011, *Shifting roles: peer harm reduction work at Regent Park Community Health Centre*, Centre for Addiction and Mental Health, Toronto; International HIV/AIDS Alliance 2015, *Good practice guide for employing people who use drugs*, International HIV/AIDS Alliance, accessed 16 March 2017, <https://www.aidsalliance.org/assets/000/001/840/Employing_FINAL_original.pdf?1445009816>; Jürgens, R 2008, “Nothing about us without us” – Greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative. *International edition*, Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute, Toronto; Penn, RA, Strike, C & Mukkath, S 2016, ‘Building recovery capital through peer harm reduction work’, *Drugs and Alcohol Today*, vol. 16, no. 1, pp. 84-94.

*peer harm reduction work at Regent Park Community Health Centre.*¹⁰⁹ The study documents the growth and development of their peer program. Due to the significant benefits of incorporating peers into their harm reduction program – both for the program and for participants – there was a seemingly natural evolution of the program to gradually incorporate peers into more and varied roles. Although they had not consciously done so, on inspection they found that a model of peer work had evolved that could be conceived of as a continuum – ranging from a low-threshold *peer participation model* towards a more involved *employment development* model.

Figure 3 (below), shows activities requiring less commitment such as kit making or public speaking placed in the *peer participation* end, while more involved tasks such as conducting outreach or temporarily relieving the duties of permanent, non-peer staff sit among the *employment development* end. Peer participation typically has more modest goals – such as basic health promotion, improving the capacities of peers (e.g. through the development of harm reduction knowledge), and developing relationships with non-peer staff – and demands very little in terms of peers’ work experience, levels of commitment, and requirements of training. On the other hand, peers in employment development roles are worked with much more closely, are required to have prior experience in peer participation roles, the goals are loftier (such as professional development, facilitating transitions into mainstream employment or *recovery*), and peers are expected to apply more dedication.

¹⁰⁹ Penn, R., Mukkath, S., Henschell, C., et al. 2011, *Shifting roles: peer harm reduction work at Regent Park Community Health Centre*, Centre for Addiction and Mental Health, Toronto.

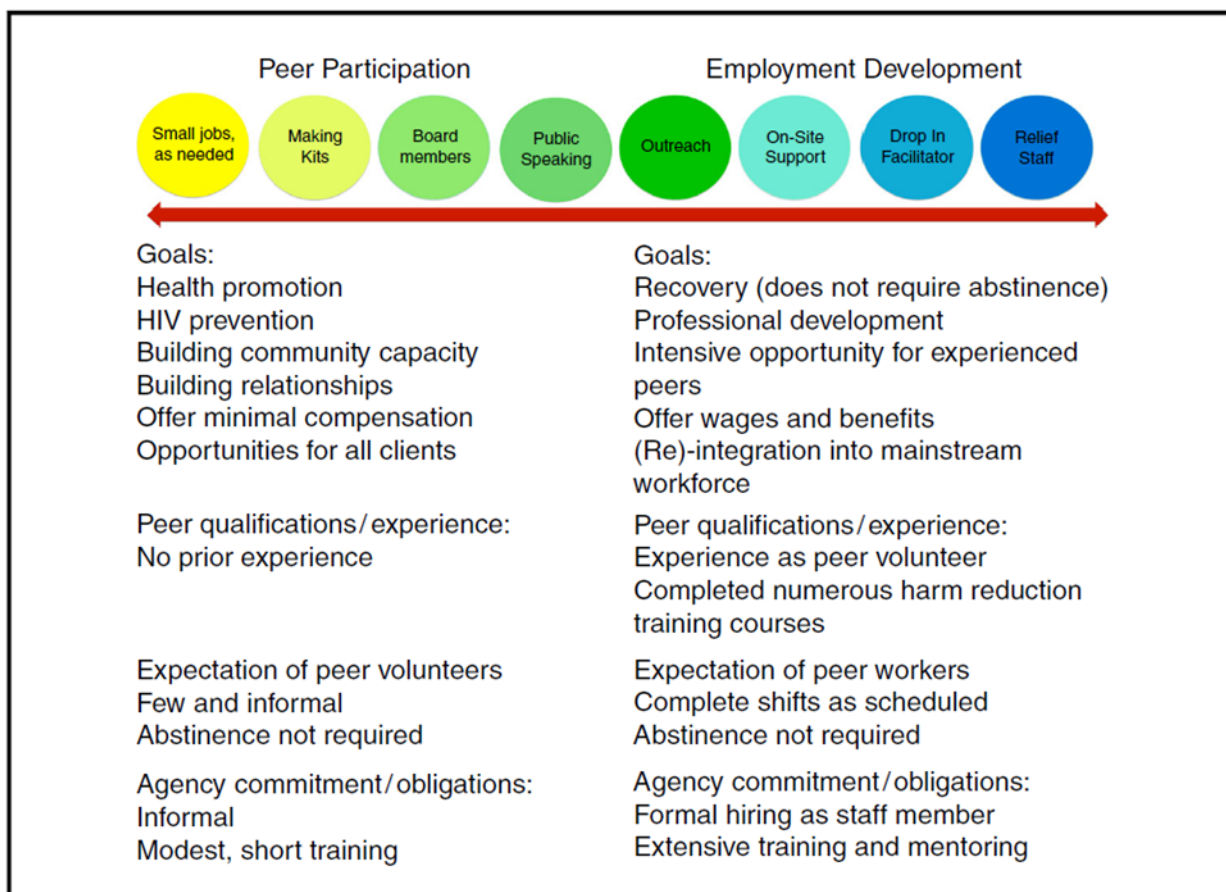


Figure 3 - The continuum of peer work as it is practiced in the Regent Park Community Health Centre's harm reduction program (Toronto, Canada), reproduced from Penn, Strike & Mukkath (2016, p. 87).

For example, having weekly drop in sessions where clients of a harm reduction service can come in to help with making up fit packs requires little commitment and responsibility, while providing opportunities to get to know the staff better, become more active in the activities of the service, and can work as a segue into other peer work/roles within the service. As a peer becomes more familiar with these kinds of low threshold roles, and the staff (both peer and non-peer) become more familiar with them, then opportunities may arise for the roles that are better characterised in terms of employment development – i.e. those which more closely resemble roles in the mainstream workforce due to their demand, commitment, skill, stability, remuneration, and so on.

Having a range of peer work opportunities available at different levels of commitment/involvement maximises the number of individuals who can become involved in peer work (typically with flow on benefits to users and their communities/networks), while simultaneously building

opportunities/pathways into more involved, formal employment for those who desire it and have the life stability to pursue it.

Reference:

Penn, R, Mukkath, S, Henschell, C, Andrews, J, Danis, C, Thorpe, M, Thompson, M, Gao, Y, Miller, C & Strike, C 2011, *Shifting roles: peer harm reduction work at Regent Park Community Health Centre*, Centre for Addiction and Mental Health, Toronto.

Elements that can facilitate [meaningful] peer integration [and recovery]:

When attempting to evaluate the state of meaningful peer engagement across British Columbia's harm reduction program, Greer and colleagues developed what they called a 'peer engagement process evaluation framework'.¹¹⁰ This involved four key domains that were considered to be integral to achieving meaningful engagement of peers:

1. Supportive environment: this includes due attention to preparing an organisation prior to introducing peer components, hiring and orientation, supervision, supporting co-worker relationships and communication, and anticipating/preparing for interactions with law enforcement.
2. Equitable participation: achieved by ensuring that all voices, perspectives, experiences and roles are equally respected and adequately represented.
3. Capacity building and empowerment: ensuring that peers are provided with adequate (professional) development opportunities and support prior to, during, and into the times after they are employed or engaged in peer work roles.
4. Improved programming and policy: responding to local experiences and risk environments to positively evolve programs and policy.

The literature contains many examples of where inadequate forethought and preparation has led to issues with integrating peer workers into existing workplaces.¹¹¹ This section refers mainly to elements that help develop the organisational culture to make the workplace more welcoming, inclusive, and sensitive to the diverse needs and life situations of peer workers.

¹¹⁰ Greer, A., Luchenski, S., Amlani, A., et al. 2016, 'Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada', *BMC Public Health*, vol. 16, no. 452, pp. 1-9.

¹¹¹ For example: Department of Behavioural Health and Intellectual Disability Services 2017, *Peer support toolkit*, Department of Behavioural Health and Intellectual Disability Services, Philadelphia, accessed 16 March 2017, <http://dbhids.org/about/organization/strategic-planning-division/peer-culture-and-community-inclusion-unit/peer-support-toolkit>

One particularly novel policy is to identify and involve an ‘executive champion’ with whom peers have direct access and who is actively dedicated to supporting them.¹¹² Such a person not only serves as a strong symbol of the organisation’s support for peer workers, but also – through their close communication – can identify barriers to their participation early on and develops solutions to overcome them. This involvement can be justified as peers do not enjoy the same structural supports that have been honed over many decades for more traditional staff. Such champions could also help to ensure that the peer program is truly integrated into the broader work of the organisation.¹¹³

Networking:

Various sources from the literature search have identified that networking is a key element in terms of capacity building for peers. The attention is focused on such aspects as: network building/strengthening as a counteraction to marginalisation;¹¹⁴ expanding networks to utilise peer workers beyond regular groups of ‘core members’ – which will assist in credibility for peer groups to claim that they represent their cohort;¹¹⁵ service users themselves consistently identifying building networks as necessary;¹¹⁶ strengthening user networks as leading to ‘community building’, with flow on benefits such as empowerment, increased wellbeing, and capacity to enact change - all on the collective level;¹¹⁷ giving legitimacy and increasing the capacity of ‘what is already going on’ in peer networks;¹¹⁸ the extent to which networks can be developed whilst still being meaningful, especially as many existing drug user networks are ‘small, personalized communities’.¹¹⁹

¹¹² Ibid.

¹¹³ Mason, K 2006, *Best practices in harm reduction peer projects*, Street Health, Toronto.

¹¹⁴ Branfield, F., Beresford, P., Andrews, E., et al. 2006, *Making user involvement work: supporting service user networking and knowledge*, Joseph Rowntree Foundation, York.

¹¹⁵ Ibid.

¹¹⁶ Ibid.

¹¹⁷ Wye, S., 2006, *A framework for peer education by drug-user organisations*, Australian Injecting & Illicit Drug Users League, Canberra.

¹¹⁸ See: Allman, D, Myers, T, Schellenberg, J, et al. 2006, ‘Peer networking for the reduction of drug-related harm’, *International Journal of Drug Policy*, vol. 17, no. 5, pp. 402-410.

¹¹⁹ Ibid.

Interactions with law enforcement:

Due to the criminality of drugs and drug use, it is important that strategies are in place for peer workers to fulfil their roles in an outreach capacity without undue interference or harassment.¹²⁰

Such strategies include:¹²¹

- Ensuring that law enforcement officers have ways of identifying peer outreach workers (e.g. picture ID or communications informing police of who the service's outreach workers are at any given time).
- Police officers should be educated on the work that peer outreach workers do and why it is valuable.
- Create partnerships with law enforcement, with the intention to create official agreements and/or letters of support.
- Form relationships with lawyers/legal services that can be contacted in the event that peer staff face legal issues during the course of performing their stated roles.
- Inviting a local police officer onto an advisory board or organising committee for peer programs.¹²²

Peers conducting training:

Opportunities should be created for peers to devise education programs that target both peer populations as well as front line workers. An example of this is from Sweden, where a nationwide HCV course aimed at both people who inject drugs and frontline workers was developed by a user organisation, whereby peers were trained to deliver the training. It was later adapted to a web-based intervention and involved a training manual that was distributed throughout Europe.¹²³

¹²⁰ Balian, R & White, C 2010, *Harm reduction at work: a guide for organizations employing people who use drugs*, Open Society Foundations, New York.

¹²¹ International HIV/AIDS Alliance 2015, *Good practice guide for employing people who use drugs*, International HIV/AIDS Alliance, accessed 16 March 2017, www.aidsalliance.org/assets/000/001/840/Employing_FINAL_original.pdf?1445009816

¹²² Mason, K 2006, *Best practices in harm reduction peer projects*, Street Health, Toronto.

¹²³ See: Schatz, E & Stalenkrantz, B 2013, 'Lever or die: peer involvement in hepatitis C prevention', in *3rd International Symposium on Hepatitis Care in Substance Users*, Munich, Germany, 5-6 September, *Suchtmedizin in Forschung und Praxis*, vol. 15, no. 4, pp. 246-247.

A PEER SUPPORT TOOLKIT - PHILADELPHIA

A Peer Support Toolkit, developed by Department of Behavioural Health and Intellectual Disability Services, Philadelphia in 2017.

The Department of Behavioural Health and Intellectual Disability Services' Peer Culture and Community Inclusion Unit developed a toolkit for administrators, directors and supervisors of treatment organisations who have hired peers into new support roles within their agency. The toolkit is an interactive PDF. The toolkit is organised into four modules, each addressing implementation relevant issues:

Module 1: Preparing the Organizational Culture

Module 2: Recruiting and Hiring Peer Staff

Module 3: Service Delivery

Module 4: Supervision and Retention

A Peer Advisory Council (PAC):

The toolkit outlines the benefits to developing a Peer Advisory Council.¹²⁴ The organisational leaders can determine the purpose of the PAC while council members determine the goals and activities. Ideally these members are service users or alumni. Sometimes this is by formal invitation by leaders in the organisation, but service users could also do this. It is suggested that staff should not become members, leaders or facilitators of PACs. In Philadelphia staff contribute by: (1) Communicating the purpose of the PAC and providing ideas about initial activities and areas of focus; (2) Promoting respect, safety, and confidentiality by supporting the PAC in establishing their group norms and structure; (3) Modelling leadership skills; (4) Assisting facilitators in preparing for the meeting and Debriefing; (5) Offering to co-facilitate the first few meetings; (6) Supporting the process and being responsive to requests; (7) Creating feedback loops so that the PAC can directly share their ideas and concerns with senior leadership and receive follow-up.

As detailed in the toolkit:

“The focus and activities of every PAC will be tailored to their community and may include the following: (1) Planning social activities; (2) Facilitating focus groups with people receiving services;

¹²⁴ Department of Behavioural Health and Intellectual Disability Services 2017, *Peer support toolkit*, Department of Behavioural Health and Intellectual Disability Services, Philadelphia, accessed 16 March 2017, <<http://dbhids.org/about/organization/strategic-planning-division/peer-culture-and-community-inclusion-unit/peer-support-toolkit/>>.

(3) Meeting with senior leadership to offer feedback and suggestions regarding service delivery approaches; (4) Conducting assertive outreach and early re-engagement; (5) Promoting initial engagement, for example, serving as greeters in the center; (6) Planning recovery celebration activities; (7) Fundraising for social activities; (8) Coordinating community education and awareness raising events; (9) Establishing partnerships with community organizations and allies that can help to meet the needs of people receiving services”.

The *Peer Support Toolkit* also outlines the importance of employing more than one peer worker at any one time to avoid too much pressure being placed on one person to represent their entire cohort. Further, having a single peer worker tends to obscure agency issues that make it difficult for them to integrate as issues tend to be blamed (inadvertently) on the individual. Authors of the toolkit noted that most of the worst-case scenarios over the past 20 years relate to services that begin their peer programs by hiring only one peer staff member to begin with. Often, they’re treated as a ‘token’ peer worker and/or quit early because they feel that they don’t ‘fit in’. If it is financially unfeasible to hire two peer staff, it is advised to consider hiring another peer volunteer or intern. Having support external to the organisation is considered another best practice step to counter the above issues.

As Cheng and colleagues note in relation to the broad mental health and addiction services, efforts need to be made to promote equitable involvement of peers across the policy spectrum: specifically, those with lived experience should be brought in to various roles for consultation, decision making and policy creation, particularly when it comes to the broader issues of HIV/AIDS, HCV and matters concerning illegal drugs.¹²⁵

Reference:

Department of Behavioural Health and Intellectual Disability Services 2017, *Peer support toolkit*, Philadelphia, USA

<http://dbhids.org/about/organization/strategic-planning-division/peer-culture-and-community-inclusion-unit/peer-support-toolkit>

¹²⁵ Cheng, R & Smith C 2009, *Engaging people with lived experience for better health outcomes: collaboration with mental health and addiction service users in research, policy and treatment*, Ontario Peer Development Initiative, accessed 10 April 2017, <https://canadianharmreduction.com/sites/default/files/Engaging%20PWLE%20-%20July%207%202009.pdf>

COMPETENCIES FOR THE MENTAL HEALTH AND ADDICTION SERVICE USER, CONSUMER AND PEER WORKFORCE (NEW ZEALAND):

Te Pou (a workforce development organisation for mental health and substance use issues in New Zealand) has developed a clear and succinct guide to the competencies required of peer workers. The guide was developed in recognition that there is much more development required to fully realise the benefits of a peer workforce.

The resource draws from national and international literature on the subject as well as consultations with service users and peer workers from around the country, which included a reference group of people currently working in peer roles in the sector.

These competencies are organised between core (generalised/all roles) and specific (for 'peer support workers' or 'consumer advisors'). While each core competency is broken up into 4-6 components, they are broadly understood as follows:

- (1) Lived experience and peer values: using one's experience as a foundation for helping others to achieve meaningful lives in situations of adversity.
- (2) Recovery, resilience and self-care: understanding these ideas and utilising them in one's work.
- (3) Professional development and boundaries: conducting oneself professionally and ethically, with a sensitivity as to how to negotiate boundaries in this unique role.
- (4) Communication: the development of communication skills to more effectively engage with both clients and co-workers.
- (5) Family, whanau,¹²⁶ culture and community diversity: understanding the roles that these have in people's lives and actively taking this into account in one's work.
- (6) Working within systems: understanding the legislation, policies, standards and systems that peer work is conducted within and attempting to incorporate peer values into them.
- (7) Human rights approach and social justice: understanding how human rights frameworks and approaches can be incorporated into peer work and aiming to work according to them.

Each competency component spans four levels depending on the intensity of the role: 'essential' for all workers; 'peer practitioner' for those with at least two years' experience; 'peer manager' for

¹²⁶ "[Whānau](#) is often translated as 'family', but its meaning is more complex. It includes physical, emotional and spiritual dimensions and is based on [whakapapa](#). Whānau can be multi-layered, flexible and dynamic. Whānau is based on a Māori and a tribal world view. It is through the whānau that values, histories and traditions from the ancestors are adapted for the contemporary world." (From Te Ara – The Encyclopedia of New Zealand: <http://www.teara.govt.nz/en/whanau-maori-and-family/page-1>)

those who are running/coordinating teams; and ‘peer leaders’ within organisations. For example, one competency develops as follows:

- (1) Essential: ‘Can describe how sharing lived experience can have an impact on self and others.’
- (2) Peer practitioner: ‘Anticipates and manages the impact of sharing lived experience on self and others.’
- (3) Peer manager: ‘Supports peer staff to anticipate and manage the impact of sharing lived experience on self and others.’
- (4) Enables staff to use their lived experience knowledge and stories in their work.

Further, these competencies are underpinned by six core values: mutuality (‘the kinship of common experience’); experiential knowledge; self-determination; participation; equity, and; recovery and hope. Like other conceptions of recovery in the literature, it is used here as the accomplishment of a self-defined meaningful life that does not *require* abstinence.

While the authors maintain that what are deemed ‘essential’ competencies in this guide are perhaps too onerous for people in lower threshold peer roles, this resource nevertheless provides a useful grounding in what is required of people in these kinds of roles.

Reference:

Te Pou 2014, *Competencies for the mental health and addiction service user, consumer and peer workforce*, Te Pou.

<https://www.tepou.co.nz/resources/competencies-for-the-mental-health-and-addiction-service-user-consumer-and-peer-workforce/536>

Evaluation of a HCV focused peer education program run by a drug user organisation in NSW:

This peer education project, conducted in three regional areas of NSW and run by a drug user organisation (DUO), was funded to reduce the spread of hepatitis C and other blood-borne viruses through the promotion of safer injecting practices.

The key objectives were to: “(1) increase knowledge of HCV and health literacy of people who inject drugs (PWID), (2) increase the involvement and participation of local PWID in their local needle and syringe programmes, (3) increase the involvement and participation of local PWID in the DUO and (4) identify and document existing barriers to ‘safer’ using.”

At each site an NSP or pharmacotherapy provider was approached to form a partnership with the DUO, and from there the DUO recruited, trained and supported volunteer/unpaid peer educators. 25 peer educators were recruited in total.

An evaluation of this project was undertaken over the period between March 2009 and March 2010. Findings from across all three sites, showed that there were more than 3000 peer education encounters and a further 2000 printed resources given out. Breaking down the topics of these encounters (n=3373), 37 per cent focused on HCV, 39 per cent on safer injecting promotion, and 24 per cent as ‘other’. It should be kept in mind, however, that most peer educators had communicated that they did not submit their reporting documentation in a ‘systematic or optimal way’ – even though the value of accurate reporting was acknowledged.

Among the cohort of peer educators, there was a variety of ways that information was communicated and credibility was established. For some, word of mouth was seen to be the most effective and appropriate form of disseminating knowledge. Other preferred to provide demonstrations of safer injecting skills; a method which builds their standing amongst their peer network. And while the majority had chosen to align themselves with the DUO for legitimacy, others believed that bringing the aspect of ‘authority’ into the mix was risky and could lead to disengagement should people feel like they’re being ‘questioned’.

The evaluation concluded that this intervention was effective in its stated objective of communicating harm reduction education to a peer network, which led to an increase in knowledge, awareness and skills. Of key interest, however was that almost one quarter of peer efforts that fell under the ‘other’ category. As one peer educator put it: “The category ‘other’ in the reporting form is where the important stuff fits, so by calling it ‘other’ and lumping it together, it gets left out in the data.”

These 'other' topics discussed included: new drugs and their risks; overdose; pharmacotherapy; housing; financial support; and criminal justice. The goal of promoting 'safer injecting' was also viewed more broadly (by some peer educators) than simply preventing the spread of BBV, and extended to include bacterial infections, vein care, and preventing scarring. Some peer educators in this project had also acted as advocates to address stigma and discrimination.

The importance of promoting activities that were not stated aims to the project revealed one important contradiction that has implications for future programs. That is, the contradiction between a 'self-determined' model of peer education, and a situation where the project scope is determined primarily by those who fund it. Ultimately, it was concluded that funders for peer-based programs need to recognise and cater for the broader needs of people who use drugs by: (1) allowing flexibility in funding parameters so that there is money for peers to provide services beyond a project's (core) stated aims; (2) being flexible in reporting outcomes, so that data collection on 'other' services provided is conducted and taken into account, and; (3) expand definitions of 'prevention', for example where hepatitis C prevention can include supporting people to continue in pharmacotherapy (as in this position a person is not needing to inject drugs – reducing risk of contracting the virus).

Reference:

Newland, J & Treloar, C 2013, 'Peer education for people who inject drugs in New South Wales: advantages, unanticipated benefits and challenges', *Drugs: Education, Prevention and Policy*, vol. 20, no. 4, pp. 304-311.

5. IMPROVING INTEGRATION AND LINKAGES

INTRODUCTION:

This section presents a range of models and interventions to improve responses for those who are vulnerable to harms associated with drugs with attention to integration and linkages across the health, education, justice and community services system.

Strengthening the distribution of naloxone is again presented in this section, by focusing on a range of different and challenging environments, such as post release prison, emergency departments, pharmacies, residential care and drug treatment centres. A broad range of examples include programs such as the extensive Scottish National Take Home Naloxone program, whereby all 15 prisons in Scotland now offer naloxone-on-release; the Prevention Point Pittsburgh outreach work in the county jail, and Queensland's case management intervention for post-released prisoners to support their broad health and social needs. The criminal justice system is an important and under-utilised venue for implementing overdose prevention strategies and is presented through numerous models from the UK, USA and Australia.

Most significant from many of the following examples is the partnerships formed across a diverse range of professions and sectors. This is shown by the Novas initiative in Ireland, which provides accommodation from people who are homeless. Novas acknowledges from their research and program work, that a multi-agency approach is likely to provide the most effective impact in preventing and responding to the problem of overdose. Pennsylvania's Overdose Task Force formed to break down information silos. A range of innovative programs have evolved from Pennsylvania, such as the 'warm hands' initiative in emergency departments, whereby contact with a recovery expert commences within the hospital ensuring a 'proper recovery plan' is made prior to discharge.

The value of partnerships is also acknowledged in a Pittsburgh hospital whereby pharmacists are working with physicians and social workers to develop an outreach program to increase naloxone prescribing.

Addressing BBVs (HIV and viral hepatitis) associated with injecting drug use is central to Australia's harm reduction approach. The joint revised 2012 document by WHO, UNODC, and UNAIDS, *Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* provides a valuable checklist of what needs to be measured and compared to progress towards set targets in scaling up comprehensive programs. The indicators relating to injecting drug use provides a useful framework for in-depth assessment of prevention,

treatment and care and support programs for people who inject drugs. The framework is useful to assess existing program such as Australia's pharmacotherapy program, which still presents challenges associated with access. The information collected from undertaking these assessments is important for policy development and ensuring effective programming and could assist in how future programs are adopted.

INITIATIVES FROM PENNSYLVANIA, USA

PENNSYLVANIA OVERDOSE TASK FORCE (OTF)

The Department of Drug and Alcohol Programs established the Overdose Task Force (OTF) in July 2013. It is comprised of representatives from the national, state, county and local levels and meets approximately quarterly. The initial goal of the OTF was to develop a rapid response mechanism to break down information silos so that law enforcement and emergency medical services could have real-time trends information more readily available to them.

Given the nature of this public health crisis, in June 2015, the OTF expanded its leadership and expanded its focus from its initial rapid response goal to include: 1) informing and driving public policy on the issue of overdose; 2) informing overdose response; and 3) strategising and planning robust responses to the crisis.

PENNSYLVANIA DRUG TAKE-BACK BOX PROGRAM

The Department of Drug and Alcohol Programs has spearheaded a greatly-expanded prescription drug take-back box program. Many young people who abuse prescription drugs are stealing them from medicine cabinets. Keeping unused opioids or other common drugs of abuse in a medicine cabinet is no longer safe or responsible. The Department, working in partnership with Pennsylvania Commission on Crime and Delinquency (PCCD) the Pennsylvania District Attorney's Association (PDAA), the Attorney General's (AG) office and the National Guard, has increased the availability of permanent prescription drug take-back boxes across the Commonwealth, with the goal of reducing the amount of prescription drugs available for potential misuse/ abuse. Since its start in January 2014, approximately 227,857 pounds of prescription drugs have been collected and properly destroyed. In 2016, approximately 124,336 pounds of prescription drugs were collected and destroyed. Currently, there are more than 580 take-back boxes placed across all 67 counties.

Reference:

<http://www.ddap.pa.gov/overdose/Pages/Department%20Focus%20on%20Addressing%20Overdose.aspx>

PRISON THROUGH-CARE (INTERVENTIONS WITHIN PRISON AND FOR POST-RELEASE PRISONERS)

Prison through-care can support prisoners by carrying out a range of interventions that can reduce risk of death. These include:

- pre-release education on overdose risks and prevention,
- continuation and initiation of substitution treatment and
- improved referral to aftercare and community treatment services.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) states that improving through-care between prison and community can prevent overdose deaths. Through-care for prisoners has been the focus of much work however protocols do not always work as effectively as desired. Monitoring of engagement between prisons and through-care services should be part of any local commissioning agreement.

Scottish Prison Service (SPS) are currently rolling out a service model based on prison officers engaging pre-release and following through in the community. As this is an opt-in service it may not be as effective with 'chaotic' drug users whose engagement with services is limited. Models that involve assertive linkage and outreach may be necessary for this group. This type of through-care model is currently being piloted in Low Moss prison with short term prisoners and an evaluation report is available.

Incarceration is common among people who inject drugs. Research has shown that incarceration is a marker of elevated risk for opioid overdose, suggesting that the criminal justice system is an important, under-utilised venue for implementing overdose prevention strategies. Based on a search of records from the Australian National Coroners Information System Andrews & Kinner¹²⁷ identified the occurrence of 388 deaths among ex-prisoners between 2000 and 2007. The investigators found that 175 (45 per cent) of these deaths were ruled as accidental drug-related deaths, and 141 as accidental overdose. Based on toxicology reports, opioids were involved in 82 per cent of the drug-related deaths, and most deaths (72 per cent) involved multiple substances. Opioids

¹²⁷ Andrews J. and Kinner S. (2012) Understanding drug-related mortality in released prisoners: a review of national coronial records. BMC Public Health. Apr 4; 12:270

were listed in 96 per cent of the cases in which multiple substances were found, used most often in combination with benzodiazepines.

In the research based in England there were high rates of overdose witnessing (73 per cent) and personal experience (54 per cent) among prisoners, but a general lack of familiarity with naloxone (83 per cent communicating little to no knowledge).¹²⁸ Often overdose prevention and THN training was provided alongside ‘recovery-oriented treatment’ and this was perceived as a mixed message.¹²⁹ The need for naloxone programs for prisoners on release was highlighted as one of nine key ‘lessons learned’ regarding THN provision in the 2016 EMCDDA report *Preventing opioid overdose deaths with take-home naloxone*.¹³⁰ A number of interventions targeting opioid users have been recommended to reduce the risk of a fatal overdose in the period shortly after prison release. They include;

- pre-release counselling on overdose risk and training in first aid and overdose management;
- optimising referral to achieve continuity of drug treatment between prison and community; and
- distribution of naloxone among opioid users leaving prison.

Reliable data about the availability of pre-release measures are scarce. However, naloxone is available on release from prison across Scotland and Wales but is not reported from other countries.

A recent study by Sondhi and colleagues investigating the barriers and challenges of implementing THN in English prisons identified four key barriers in the distribution and implementation of naloxone.¹³¹ These include:

1. A wide range of negative and confused perceptions of THN amongst prison staff and prisoners – including confusing naloxone with pharmacotherapy drug naltrexone, that carrying naloxone meant that you could not be serious about abstinence as well as demonstrating to authority figures (such as police or rehabilitation administrators) that you were a current user, and that naloxone provided an incentive to use opiates;
2. Inherent difficulties with the identification and engagement of eligible prisoners – such as there being no way to automatically ‘flag’ prisoners who had a history of opiate use, finding

¹²⁸ Sondhi, AC 2016, ‘Addressing perceptions of opiate-using prisoners to take-home naloxone: findings from one English region’, *Drug and Alcohol Today*, vol. 16, no. 2, pp 124-130.

¹²⁹ Sondhi, AC 2016, ‘Addressing perceptions of opiate-using prisoners to take-home naloxone: findings from one English region’, *Drug and Alcohol Today*, vol. 16, no. 2, pp 124-130.

¹³⁰ See reference vii.

¹³¹ Sondhi et al. Stakeholder perceptions and operational barriers in the training and distribution of take-home naloxone within prisons in England *Harm Reduction Journal* (2016) 13:5

sufficient numbers of people to train, determining criteria for who should receive the training, prisoners being transferred between the time in which they indicated interest in THN training and when they could be given the training and a kit, and identifying and engaging prisoners who were only in with short sentences travelling in and out prior to THN training;

3. The need to focus on individual prison processes to enhance the effective distribution of THN – with clinicians typically being the only people who could train in THN and provide kits it limits the ways that this intervention could be provided, and there was uncertainty as to where a THN kit could be stored (according to prison policy) once a prisoner had received the training and a kit; and
4. The need for senior prison staff engagement to ensure continuing support and feasibility of the program and facilitating a ‘culture change’ that would see staff as generally understanding and being sympathetic to THN as an intervention.

This 2014 WHO report; *Preventing overdose deaths in the criminal-justice system* updates information contained in an earlier 2010 WHO report: *Prevention of acute drug-related mortality in prison populations during the immediate post-release period*. The report identifies the main areas that need to be improved to reduce the risk of death in the criminal justice system, arguing that linking prison-health and public-health systems closely is essential to mitigating this risk. Preventive responses are considered across all levels of the justice system. The report includes a literature review that identifies a substantial body of research from various countries, which supports the finding that there is a significantly heightened risk of overdose death during the initial post-release period.

Best practice in system-wide service delivery for drug dependent prisoners requires a range of treatment options founded on evidence-based practices. This requires that interventions incorporate flexible client-centred programmes, utilizing a multiphase interdisciplinary approach of an equivalent standard to community interventions. The WHO Regional Office for Europe has outlined harm reduction strategies of relevance to prison populations. These include:

- needle and syringe exchange programs,
- educational measures in the form of overdose prevention programs,
- formalised information dissemination,
- outlines of treatment expectations and peer-based support, and
- pharmacotherapy. (WHO p15)

NALOXONE-BASED OVERDOSE PREVENTION TRAINING AMONG PREVIOUSLY INCARCERATED SYRINGE-EXCHANGE PROGRAM PARTICIPANTS

The aim of the study by Barocas and colleagues, based in Midwestern United States, was to improve understanding of the acceptability and current uptake of naloxone-based overdose prevention training among people who inject drugs who interact with the criminal justice system. The study demonstrates that people who inject drugs with a history of incarceration appear to have a higher risk of opioid overdose than those never incarcerated, and are more willing to utilise naloxone as an overdose prevention strategy. Naloxone training and distribution is an important component of comprehensive prevention services for persons with opioid use disorders. Expansion of services for persons leaving correctional facilities should be considered.

Reference:

Joshua A. Barocas, Lisa Baker, Shawnika J. Hull, Scott Stokes, Ryan P. Westergaard (2015) High uptake of naloxone-based overdose prevention training among previously incarcerated syringe-exchange program participants *Drug and Alcohol Dependence*, 154 283–286

PREVENTION POINT PITTSBURGH - TAKING OVERDOSE PREVENTION INTO THE JAILS TO REACH THOSE AT RISK

In 2000, Allegheny County established the Jail Collaborative, a cooperative effort among the Allegheny County Jail, Department of Human Services, Health Department, Court of Common Pleas, and community partners with the purpose of reducing recidivism and increasing success for inmates following incarceration by focusing on treatment and services in the jail as well as intensive support for inmates and ex-offenders.

To date, over 6,700 inmates have been trained. The program is considered an overwhelming success. “We see lots of people at the needle exchange for naloxone who say they learned about us from the jail trainings.”

Reference:

Wheeler, E, Burk, K, McQuie & Stancliff, S 2012, *Guide to developing and managing overdose prevention and take-home naloxone projects*, Harm Reduction Coalition, New York.

N-ALIVE TRIAL

N-ALIVE (NALoxone InVEstigation) is a large, prison-based, randomised controlled trial assessing the number of lives that could be saved by provision of naloxone-on-release to adult prisoners with a history of heroin injection. The first efforts to provide THN training to prisoners upon release was made in England with the N-ALIVE randomised control trial.¹³²

Conducted across 16 prisons from May 2012 to December 2014 it involved 1685 participants. The committee that oversaw the trial recommended that (non-randomised) THN provision to prisoners on release should be continued. Following this trial, similar THN programs have been implemented in two prisons in the US (San Francisco and Rhode Island) and one prison in Russia. While the N-ALIVE trial aimed to reduce overdose death for prisoners who had been released, it was found that most participants reported using naloxone on others rather than having others use it on them.

Principal question asked:

- Pilot trial: What happens to the naloxone and the participants, in terms of heroin use and overdoses (witnessed or experienced) within four and 12 weeks after release?
- Main trial: Does giving naloxone on release to prisoners with a history of heroin injection reduce heroin overdose deaths by 28 per cent in the first 12 weeks after release?

Reference:

<http://www.kcl.ac.uk/ioppn/depts/addictions/research/drugs/N-ALIVE.aspx>

Strang, J and McDonald, R (eds) 2016, *Preventing opioid overdose deaths with take-home naloxone*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon.

QUEENSLAND TRIAL A CASE MANAGEMENT INTERVENTION FOR ADULT PRISONERS/EX-PRISONERS

A randomised controlled trial is currently being conducted in Queensland, Australia, to evaluate an intervention involving services for ex-prisoners whereby, on being released, each inmate is provided with an information package that includes a “passport” detailing the individual’s health status and a list of relevant health resources. The individual receives a series of follow-up calls designed to encourage use of the information in the passport. The aim of this study was to evaluate the impact of a case management intervention for adult prisoners/ex-prisoners on contact with primary care,

¹³² Strang, J and McDonald, R (eds) 2016, *Preventing opioid overdose deaths with take-home naloxone*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon.

mental health (MH) services, and alcohol and other drug (AOD) treatment services, in the first six-months post-release.

Recruitment and baseline interviews occurred over a two-year period from August 2008 to July 2010. The intervention consisted of two components. First, based on data collected during the baseline interview, participants in the intervention group received a personalised booklet ('Passport') at the time of release from prison. The Passport included three sections:

1. a step-by-step guide to key re-entry tasks such as securing accommodation and income,
2. a plain language and graphical summary of the participant's health status and treatment needs; and
3. a list of relevant community services addressing health and psychosocial needs, tailored to the participant's demographic characteristics, health status and expected location post-release.

The second component of the intervention involved contacting participants by telephone on up to four occasions during the first 28-days post-release (ideally once a week). Intervention calls were delivered by trained staff, focused on basic health promotion and the identification of services to meet identified health and psychosocial needs and were informed by principles of motivational interviewing.

This is the first ever randomised trial to specifically evaluate case management in ex-prisoners and the first evaluation of transitional case management outside of North America. Findings show that a brief and low-intensity intervention can have a significant and sustained impact on healthcare usage for ex-prisoners.

Reference:

Kinner S.A., et al. Low-intensity case management increases contact with primary care in recently released prisoners: a single-blinded, multisite, randomised controlled trial *Journal of Epidemiology and Community Health* 2016; 70:683–688

PRISON BASED HEALTHCARE INTERVENTION FOR HEPATITIS B

A recent example of a healthcare intervention that has been successfully integrated into prison-based routine care is hepatitis-B vaccinations in the United Kingdom. Prisoners in the United Kingdom are now all offered hepatitis-B vaccination on an opt-out basis.¹³³ This could serve as an implementation model for future prison-based take-home naloxone schemes targeting (former) opioid users at release.¹³⁴

PREPARING PRISONERS TO AVOID DRUG OVERDOSE

This is a program to prepare prisoners to avoid drug overdose death associated with the transition to the community by training them in overdose prevention and making naloxone available. The program is considered a milestone collaboration in the USA between public health, the correctional system, and a community-based harm reduction program in response to the growth of heroin and opioid analgesic use and related morbidity and mortality, working together to get naloxone into the hands of the people at high risk of overdosing and/or of witnessing an opioid overdose.

A pilot at a minimum-security correctional facility in New York City was initiated in February 2015 and targets soon to be released inmates to educate them about the risks of opioid use, especially after periods of confinement, and train them in the use of naloxone. Naloxone (intranasal use) is offered to trained inmates free of charge at release.

Harm Reduction Coalition staff trained inmates in the use of naloxone, as well as prison staff who then can provide the training. As of September 2015, more than 700 inmates have been trained at Queensboro Correctional Facility; about 200 have received kits. The numbers of inmates taking kits at release has increased each month, suggesting growing acceptance of the program. Training has been initiated in two other correctional facilities and several others have scheduled staff trainings. In addition, a community-based organisation in the region is training family members and friends of incarcerated individuals and equipping them with naloxone free of charge. To complement these efforts, parole officers are now also being trained.

Reference:

Zucker, H., Annucci, A., Stancliff, S., et al (2015) Overdose prevention for prisoners in New York: a novel program and collaboration, *Harm Reduction Journal*, 12:51

¹³³ Sutton, A., Gay, N., Edmunds, W., et al (2006). Modelling the hepatitis b vaccination programme in prisons. *Epidemiology and Infection*, 134(2), 231–242.

¹³⁴ European Monitoring Centre for Drugs and Drug Addiction 2016, *ibid* p.87.

SCOTLAND'S NATIONAL NALOXONE PROGRAMME: THE SCOTTISH PRISON SERVICE PROVISION OF NALOXONE-ON-RELEASE

In 2012, the Scottish Government invested in a National Take Home Naloxone program providing a national coordinator, support for development of local naloxone programs including naloxone kits for at-risk prisoners upon release from incarceration, financial support for distribution of naloxone kits, and a national monitoring and evaluation program. All 15 prisons in Scotland now offer naloxone-on-release.

The most recent data from the Scottish National Naloxone program shows a fall in overdose death rates. In 2012 and 2013 the percentage of opioid-related deaths occurring within 4 weeks of prison release (5.5 and 4.7 per cent) was almost half that of the pooled 2006–10 baseline indicator (9.8 per cent), suggesting that distribution of naloxone kits on release may reduce the risk of fatal overdose among (former) prisoners with history of opioid use [48]. (Taken from McDonald 2016 systematic review)

Current data suggest at least 20 per cent and best estimate of 36 per cent reduction in prison release ORDs, which may be due directly to the programme.

Reference:

- 1) Scottish Drugs Forum (2016), *Staying alive in Scotland: strategies to combat drug related deaths*, Scottish Drugs Forum, Glasgow.
- 2) McDonald, R. and Strang, J.(2016) Are take-home naloxone programmes effective? Systematic review utilizing application of the Bradford Hill criteria. *Addiction*: 111 97); 1177-87.

WEBINAR HOSTED BY SAHMSA ON RECOVERY POST-RELEASE PRISON

More than half of the 2.2 million people incarcerated in the United States have mental health conditions, substance use disorders, or both. Each year in the United States, hundreds of thousands of people with behavioural health needs leave prison or jail and return to their communities. This transition is fraught with challenges, including barriers to accessing treatment and recovery supports, obtaining public benefits, finding employment, regaining custody of children, and gaining stable housing.

Peer support from individuals with lived experience of mental health conditions, substance use disorders, and criminal justice system involvement is a critical resource for people transitioning back

to their communities. Re-entry-focused peer supports can help people achieve and maintain their recovery and to successfully re-join their families and communities after incarceration

This webinar reviews emerging evidence about the value of peer specialists and recovery coaches in supporting individuals transitioning from incarceration. It highlights effective approaches to help individuals develop and advance towards their recovery and wellness goals, access services, navigate systems, and achieve successful community integration. *Original Air Date: June 30, 2016*

[Recovery After Incarceration: Peer Supports as a Critical Re-Entry Service \(link is external\)](#)

THROUGH-CARE MODEL – LOW MOSS PRISON

This Public-Social Partnership (PSP) was developed in consultation with key stakeholders, including prisoners and ex-offenders and became operational in May 2013. The Low Moss PSP is one of a number of projects the Scottish Government supports to help prisoners and other offenders rehabilitate themselves. This includes the Reducing Reoffending Change Fund which, in partnership with The Robertson Trust and Scottish Prison Service, funds the development and delivery of offender mentoring PSPs and provides flexible one-to-one support to offenders.

The Public-Social Partnership set out to develop and test a new approach to improve the through-care support provided to short-term offenders. The development of the service was in response to the evidence that people serving short-term sentences often faced complex issues that could affect the likelihood of reoffending and that there was no access to coordinated support to tackle the issues. The PSP brought together a ‘pathway’ of through-care support, from an individual’s reception into custody, through their time in custody and on release and in the community.

The Low Moss PSP was set up in 2013 to identify and address the underlying complex issues why a high level of people serving short term sentences would go on to reoffend.

The PSP identifies and addressed the problems people preparing to leave prison face returning to their community, improves engagement with services and contributes to a reduction in offending behaviour. Findings revealed that a lack of access to housing, appropriate welfare support and medical support greatly increased a person’s chances of reoffending.

The program worked with service users facing complex and wide-ranging issues and had ‘made a difference’ and contributed to several positive outcomes for those who received support.

The evaluation of the program showed a positive impact on people's physical and mental well-being. 40 per cent of service users reported an improvement in their physical health and 44 per cent in their psychological well-being. A reduction in substance misuse and risk taking was identified with 42 per cent of service users reporting an improvement. Overall nature of the PSP service provision – a coordinated holistic approach, an embedded service, voluntary participation, informal, independent and confidential approach, quick access to support, inclusion of specific types of support (duty system, liberation day support, assertive outreach, continuation of support linked to needs).

Good Practice Indicators

- Support is in place at liberation that ensures benefits are in place for those eligible to claim.
- Peer support networks are made available in prison and on liberation to support reintegration into community i.e. Smart recovery, NA, and ORT.
- All prisoners are assessed prior to liberation regarding potential drug related risk behaviours.
- Pre-release education on overdose risks and prevention is available at release from prison.
- Addiction services are informed of high risk individuals prison liberation dates. Provision is in place for continuation/initiation of ORT in the community including weekend release.
- Individuals at risk of opiate overdose are referred to prison through-care services.
- All prisoners with a history of opiate use are offered a supply of naloxone on liberation.
- Families of prisoners are offered overdose awareness and naloxone training in preparation for the prisoner's release. People released from police custody receive a supply of naloxone.

Workforce Development Considerations

- Local Scottish Prison Service staff are trained and equipped to deal with opiate overdose emergencies.
- Police custody suite staff are trained and equipped to deal with overdose emergencies.
- Through-care staff training should include risks of drug overdose and harm reduction practices.

Reference:

<http://www.academyforjusticecommissioning.org.uk/wp-content/uploads/2016/01/Case-Study-Public-Social-Partnership-Low-Moss-Prisoner-Support-Pathway.pdf>

BOLWARA HOUSE TRANSITIONAL CENTRE INITIATIVE

Bolwara House Transitional Centre in New South Wales, Australia, offers an intensive community based pre-release programme for women with a history of drug addiction. This non-custodial therapeutic community provides structured transitional support that implements through-care principles. It incorporates pharmacotherapy, psychosocial development and family and community reintegration in a holistic client-centred approach. The program consists of two phases, beginning with a four-week in-house deinstitutionalisation process, after which time women commence community programmes based on their assessed needs. Such programs include paid or voluntary employment, accommodation, parenting and education. This fosters social inclusion and rehabilitation while strengthening competences, personal resources and self-esteem.

Reference:

World Health Organization 2014b, *Preventing overdose deaths in the criminal-justice system*, World Health Organization: Regional Office for Europe, Copenhagen. p.16

ABORIGINAL OFFENDER SUBSTANCE ABUSE PROGRAM IN CANADA

The Aboriginal Offender Substance Abuse Program in Canada is a national intervention that helps aboriginal men holistically address their drug dependence and offending behaviour. This program includes Opioid Maintenance Therapy and examines substance use in terms of interpersonal and transgenerational trauma. Traditional techniques, such as cultural healing practices and re-establishment of spiritual connectedness, are applied in conjunction with current therapeutic measures, including risk management and skill development (102). In this way, the program confronts the causes of aboriginal drug addiction by implementing culturally appropriate strategies.

Reference:

World Health Organization 2014b, *Preventing overdose deaths in the criminal-justice system*, World Health Organization: Regional Office for Europe, Copenhagen. p.16

NOVAS INITIATIVES – OVERDOSE AMONG HOMELESS PEOPLE

Novas Initiatives is the largest provider of homeless accommodation in the Mid-Western region, Ireland. McGarry House, a program of Novas opened in 2002, and provides accommodation for 30 individuals and long-term supported housing for 37 individuals who are homeless. The house operates with a harm reduction ethos (safe disposal bins for needles in resident's rooms and provision of harm reduction based interventions by staff, etc.). In recent years, the profile of residents has changed; becoming younger, and engaging in more chaotic drug use with increasing levels of opiate use.

In an 18-month period, between May 2012 and November 2013, staff responded to 34 overdoses; an average of one overdose every two weeks. At that time, McGarry House had also been working with several women who were pregnant and at high-risk from substance use.

The staff used the Housing Opiate Overdose Risk Assessment Tool to measure the extent of risk of overdose in the project: From the assessment 16 residents were judged to be at high risk of overdose, including a number of women who were pregnant. Managing this risk proved immensely challenging for the staff team.

A research project was conducted to better understand overdose among homeless people so services like McGarry House can:

- Provide better support to people to help them reduce their risk of overdose;
- Help people to respond better if witnessing someone who is overdosing; and
- Constantly improve responses to overdose when it happens.

The research identified effective mechanisms for:

- Increasing knowledge of overdose risk and overdose prevention among residents and staff;
- Decreasing risk taking behaviour among the resident group; and
- Increasing effective bystander responses to overdose.

Acknowledging that a multi-agency approach is likely to provide the most effective impact in preventing and responding to the problem of overdose, there was strong sentiment amongst both the team in McGarry House and among external service providers and stakeholders of the importance of interagency working in effectively preventing and responding to overdose.

Recommendations relevant to addressing overdose include:

Recommendation 11: INTERAGENCY PROTOCOLS: EMERGENCY SERVICES

To support optimal interagency communication between McGarry and Emergency Services, it is recommended that interagency protocols be formalised to agree and guide: consent for sharing information, requirements for discharge letters from the hospital to support readmission to McGarry and a system for communicating regarding inappropriate referrals. In addition to this, information sessions by the emergency services to Novas staff on communicating during overdose with emergency professionals could help to implement this.

RECOMMENDATION 12: PERSON CENTRED ASSESSMENT TRAINING

Person-centred risk assessment training is developed and undertaken collaboratively by the Homeless Person's Centre and Novas. Concern that residents are not providing key risk information at risk assessment because they are concerned about negative consequences for service users if they disclose their drug use – negative consequences may include not getting a bed, or feeling judged. The aim of training is so staff can encourage service users to feel comfortable providing information such as drug use, which can indicate overdose risk at an early point.

RECOMMENDATION 13: GP AND PHARMACIST COMMUNICATION

A standard information letter can be developed for GPs and pharmacists which details McGarry's role in relation to medication management and overdose prevention. This is to support shared understanding and ensure that GPs have the information required to undertake appropriately robust overdose prevention measures.

RECOMMENDATION 14: SUPPORTING HIGH-RISK PREGNANT DRUG USING WOMEN

Develop an interagency response including relevant services such as McGarry, addiction services, maternity and social work services to consider responses not limited to but including:

- The instatement of a clinical support such as the Drug Liaison Midwife Service in the region
- The needs of staff in services working with this group including information, education and access to specialised professional advice
- A broader strategic holistic approach in the region looking at and responding to the needs of women who have substance misuse issues, including pregnant women, in relation to treatment and other support.

Reference:

Dermody A., Gardner C., Quigley M., & Cullen W. (2014), *Heads up: preventing and responding to overdose in McGarry House*, Novas Initiatives, Limerick.

YOUNG PERSON'S SUPPORT PROGRAMME: A PROGRAMME FOR YOUNG PEOPLE LIVING WITH SUBSTANCE MISUSE IN THE HOME

- National Family Support Network, Ireland

This program was developed as a result of contacts made by a number of groups across Ireland working with families of people with problem drug or alcohol use, to the National Family Support Network. A need was identified for targeted support for young people living with problem substance use. A formal and structured approach to supporting these young people was identified as needed.

The Young Persons' Support Programme is delivered in 1.5 hour sessions over ten weeks (modules) through a variety of methods including group discussion, individual reflection, role-play, creative play, arts and crafts, and games. It was developed as a pilot by the National Family Support Network in conjunction with research charity Quality Matters, using an evidence base and drawing on established models used with other groups. An evaluation was undertaken in 2015 focusing on outcomes for the young people and the process of the programme delivery.

The program supports the development of coping skills in young people living with problem drug or alcohol use in their homes. The aim of the Young Persons' Support Programme is to support young people to develop improved awareness and understanding of the challenges they face and positive ways to cope with them, and to teach skills for resilience and coping, in a supportive and non-judgemental environment.

The resource:

<http://qualitymatters.ie/wp-content/uploads/2016/01/Young-Persons-Support-Programme.pdf>

ST JOHN OF GOD HOSPITAL AND BARWON YOUTH - YOUTH ENGAGEMENT PROGRAM (YEP)

This is an AOD harm reduction program intended to engage young people with AOD problems. The YEP program was created in August 2007 to significantly reducing AOD-related harm through the delivery of accessible, inclusive and opportunistic holistic services, including assertive outreach, as well as through education for early or preventative intervention.

The YEP model is designed to provide young people, particularly those who are difficult to reach, with access to services within the community. The YEP program is conducted in out-of-office settings (streets, homes, parks etc.) and is a less formalised engagement process than those used in comparable programs. Based on a social model of health, the program does not provide one single treatment method, but rather uses several approaches that are relationship based, holistic, narrative, and client centred. Importantly, it is a flexible approach based on client context.

Assertive outreach

The purpose of these programs is to actively reduce AOD-related harm in service users by developing a rapport between them and their caseworker to enhance their ongoing coping skills and independence. This process includes fostering optimism and building interdependence, resilience and community connectedness. Consistent worker–client contact is maintained by achieving a consistency of presence and flexibility in meeting with young people in their own environments and in a range of youth-friendly settings.

Goals are set using an individual treatment plan (ITP), in collaboration with the young person, and after a comprehensive assessment. The plan specifies the nature of contact workers will have with the young person and sets out the young person’s issues and goals and the steps or tasks required for reaching each goal. Outreach workers structure their contact with young people based on the ITP and the client’s current circumstances and presentation. For example, at the end of an episode of care, the outreach worker may have contact only fortnightly, with some additional telephone contact, whereas if a client is in distress, workers may have daily contact, including assertive, street-based interventions.

Episodes of care are the critical measuring tool for reaching YEP targets. These have been developed using the then Victorian Department of Human Services (DHS) output measures for funded drug treatment services and are defined as “a completed course of treatment undertaken by a client under the care of an alcohol and drug worker which achieves significant treatment goals” (DHS

1998). Significant treatment goals are taken directly from the ITP and include the outcomes of improved health and wellbeing of the young person.

Reference:

McKenzie, S., Droste, N., Hickford, S et al. (2011) Reducing alcohol and other drug-related harm in young people: Evaluation of a youth engagement program *Youth Studies Australia* vol. 30 n 4.

HEALTH CARE SETTINGS:

PROVIDING INTERVENTIONS IN PHARMACIES

Australia is only the second country in the world (after Italy) to make naloxone available over the counter. Pharmacies provide a high-yield setting where customers (patient and caregiver) can access naloxone. Pharmacists are potentially well positioned to increase opioid safety, counsel patients, caregivers and customers about overdose risk reduction, and provide naloxone kits to the community. Just because pharmacists can dispense naloxone, doesn't mean they will stock naloxone or promote it.

PHARMACISTS IN AN OUTREACH CAPACITY- OUTREACH LETTERS

The program is run by UPMC St. Margaret Hospital in Pittsburgh, US. In 2014, UPMC St. Margaret Hospital also began a harm reduction strategy in three patient-centred medical homes. It is a training site for physicians, pharmacists and social workers. The aims of this project were to increase naloxone prescribing, decrease opioid use, enhance provider satisfaction, and prevent opioid overdose deaths.

In 2014, an intervention was developed to trial 'outreach letters' that invited at-risk people to a counselling-based THN intervention. The letters were developed through consultations with physicians, social workers and pharmacists, and invited those who had either admitted to past opioid use or who had been prescribed opioids for chronic pain to attend a session with a pharmacist and receive a free take-home naloxone kit.

From 71 outreach letters that were sent out, the program dispensed 97 naloxone kits, and has learned of five successful reversals as a result. Of those who were given take-home naloxone kits, 60 per cent were illicit drug users, 34 per cent sufferers of chronic pain, and four per cent were 'concerned third parties'. An inter-professional approach was foundational to the success of

changing the provider culture. The naloxone counselling protocol developed is the result of collaboration among providers from the professions of medicine, pharmacy, and social work. Clinical pharmacists took the lead in obtaining naloxone kits and developing teaching protocols. Social workers provided counselling and case management services to address substance use issues. Demonstrating collaborative care to learners from each of these professions prepared them for rewarding futures in primary care.

Reference:

Hill, L., Naloxone counseling for harm reduction and patient engagement *Pharmacotherapy* 2015; 35(11): e269-70.

LOCAL PHYSICIANS AND PHARMACISTS WORKING TOGETHER TO INCREASE ACCESSIBILITY TO NALOXONE

Case study – Prevention Point Pittsburgh:

Prevention Point Pittsburgh, Pennsylvania, works with local physicians and pharmacists to increase the accessibility to naloxone for individuals who are legitimately prescribed opioids for pain, in addition to those who may be abusing prescription pain medications. The model uses pharmacists to educate patients and physicians about opioid safety and the effectiveness of prophylactic prescription of naloxone to prevent fatal overdose. It is now a routine part of opioid safety training for patients prescribed opioids for pain.

The program began in 2011. Patients presenting to the pharmacy with an opioid prescription were offered counselling on opioid safety, including potential side-effects, how to take them safely, possible signs of overmedication/overdose, and safe disposal of unused prescription medicines. They were also provided with overdose education materials and taught how to recognise and respond to overdose, and how to use naloxone. Once counselling is completed the patient can then request a prescription for naloxone. The pharmacist facilitates this process by faxing a simple form requesting the prescribing physician to sign a naloxone prescription (for emergencies) alongside the prescribed opioids. Once the request is approved, the prescription is filled and naloxone dispensed. The patient initials a form confirming they have received the education/training on take-home naloxone/overdose prevention and this is returned to physician to go into patient records.

Reference:

Wheeler, E, Burk, K, McQuie & Stancliff, S 2012, *Guide to developing and managing overdose prevention and take-home naloxone projects*, Harm Reduction Coalition, New York.

PARAMEDICS

THE PATHFINDER FEASIBILITY STUDY, SOUTH WALES

This feasibility study involves paramedics from the five ambulance stations in the Cardiff and Vale of Glamorgan area of South Wales. The study is currently running, but no longer recruiting participants. The aim of this study is to see whether it is possible for paramedics to supply THN kits to patients they have treated and have subsequently recovered from an opioid overdose. Patients continue to be treated as they would normally, including being advised to attend hospital for further assessment. However, those patients who demonstrate complete recovery following treatment will be offered a THN kit by the paramedic.

The intervention involves: Following a 999-emergency call and resuscitation for an opioid poisoning, paramedics trained to provide the intervention will offer THN kits to fully recovered, consenting patients. Paramedics will supply this intervention under the auspices of a patient group direction. The intervention may be provided at the scene of the opioid overdose, or while en route to hospital. This intervention has the following components:

- Training for participating paramedics;
- Protocol for the supply of THN to patients who have suffered and recovered from an opioid poisoning;
- Issue of an individual THN kit to trained paramedics which will be replaced each time they issue their kit to a patient;
- Supply of THN and education related to its use, and resuscitation techniques and procedures, to patients.

Provision of the intervention is dependent on the patient remaining engaged and their health status remaining stable during the training and consent process. Patients who do not complete the training or consent process are not supplied a THN kit. To improve adherence to the study protocol, paramedics are provided with individually assigned THN kits, to promote a sense of value and ownership. Regular newsletter updates are supplied on progress of the study to participating ambulance stations, to maintain awareness of participating paramedics.

Reference:

Moore C, Lloyd G, Oretti R, et al. Paramedic-supplied 'Take Home' Naloxone: protocol for cluster randomised feasibility study. *BMJ Open* 2014; 4.

EMERGENCY DEPARTMENTS

WARM HAND-OFF INITIATIVE – PENNSYLVANIA, USA

This initiative provides the opportunity for patients to begin to commence their recovery immediately following the life-saving intervention that they received. Young Physician Trustee for the Pennsylvania Medical Society (PAMED) and the Pennsylvania departments of Health and Drug and Alcohol Programs partnered to fight the rising number of overdoses by developing a number of initiatives, including education on the "Warm Hand-off" (also called "referral for treatment") to aid in the identification and treatment of individuals addicted to opioids. The program was launched in February 2017.

It is during a hospital visit that the warm handoff should be initiated. Patients are contacted either in person or by phone by recovery experts and the next step in their road to recovery is discussed. The goal of this initiative is to ensure that patients who are identified with an opioid addiction be offered a treatment plan immediately following the resolution of their medical emergency.

Due to the lack of available inpatient rehabilitation centres in some areas of Pennsylvania, patients were previously given resources and discharged from the hospital without a proper recovery plan in place. The warm hand-off begins to address this issue and places these individuals in direct contact with recovery experts to begin the intervention, assessment, and referral to treatment prior to their discharge.

At the Reading Hospital's Emergency Department, we are already seeing an increase in patients' willingness to accept this important intervention and start their path to recovery.

Reading Hospital has developed a plan in conjunction with the Council on Chemical Abuse (COCA) to identify and refer patients in need of assistance directly to specialists in real time. Also, by creating a "hard stop" in our electronic health record when caring for and ordering consultations for mental health and substance abuse patients, we have been able to increase physician awareness of this life-saving process and ensure a greater utilization of this resource.

The protocol/clinical pathway provide guidance on how to counsel an overdose survivor about their overdose and how to strongly encourage him or her to enter treatment immediately for drug

addiction. The protocol/clinical pathway document is available here:

<https://www.paacep.org/SiteAssets/Images/flow.pdf>

Reference:

Kristen Sandel, *What Is the 'Warm Hand-Off' and How Can It Help Pennsylvania's Opioid Abuse Crisis?*

<https://www.pamedsoc.org/Pages/Article-Detail-Page.aspx?TermStoreId=ab8b8fe3-5cb2-4091-916b-64792bec3d05&TermSetId=a6d4659a-154c-4b15-8266-4135869cd8f0&TermId=91040154-37e4-41c6-9be0-8c5a3b26757e&UrlSuffix=BlogMay1816>

EMERGENCY DEPARTMENTS AND TAKE-HOME NALOXONE

THN dispensing and education via emergency departments is a promising way to reach the 'hidden population' of prescription drug users. Nasal naloxone appears to be preferred in this setting.¹³⁵

There are two main areas covered in the published research on take-home naloxone in emergency departments.

1. literature outlining current programs (typically in pilot stages) demonstrating their acceptance and feasibility.¹³⁶¹³⁷¹³⁸
2. literature examining professional attitudes towards THN in emergency departments.¹³⁹¹⁴⁰

The first study that examined the viability of THN dispensing (with accompanying overdose prevention education) through an emergency department was conducted between January 2011 and February 2012 in Boston, USA. Of the 415 participants (most of whom were given naloxone kits) there was a low response rate for follow up interviews (12 per cent), with 32 per cent of

¹³⁵ Tobin, KE, Gaasch, WR, Clarke, C, MacKenzie, E & Latkin, CA 2005, 'Attitudes of emergency service providers towards naloxone distribution programs', *Journal of Urban Health*, vol. 82, no. 2, pp. 296-302.

¹³⁶ Samuels, E 2014, 'Emergency department naloxone distribution: a Rhode Island Department of Health, Recovery Community, and Emergency Department partnership to reduce opioid overdose deaths', *Drug and Alcohol Disorders and Treatment*, vol. 97, no. 10, pp. 38-39.

¹³⁷ Liu, M, Mazur-Routsolias, JC, Lu, J & Aks, SE 2013, 'Outpatient prescription naloxone in a county hospital emergency department: a pilot program', in *Annual Meeting of the North American Congress of Clinical Toxicology*, Atlanta, United States, 27 September - 2 October, published in *Clinical Toxicology*.

¹³⁸ Dwyer, KH, Walley, AY, Langlois, BK, Mitchell, PM, Nelson, KP, Cromwell, J & Bernstein E 2015, 'Opioid education and nasal naloxone rescue kits in the emergency department', *Western Journal of Emergency Medicine*, vol. 16, no. 3, pp. 381-384.

¹³⁹ Dwyer, KH, Samuels, L, Moore, RL, Langlois, BK, Mitchell, PM, Grimsman, J & Bernstein, E 2013, 'Physician attitudes and perceived barriers to prescribing nasal naloxone rescue kits in the emergency department', in *American College of Emergency Physicians Forum*, Seattle, United States, 14-15 October, published in *Annals of Emergency Medicine*.

¹⁴⁰ Tobin, ibid

interviewees who received take-home naloxone and witnessed an overdose reported administering naloxone at these events.

The authors concluded that THN dispensing in the setting of emergency departments is a promising avenue that should be pursued further.

Reference:

Dwyer, KH, Walley, AY, Langlois, BK, et al, 2015, 'Opioid education and nasal naloxone rescue kits in the emergency department', *Western Journal of Emergency Medicine*, vol. 16, no. 3, pp. 381-384.

ATTITUDES AND BARRIERS TOWARDS PRESCRIBING AND DISPENSING TAKE-HOME NALOXONE IN EMERGENCY DEPARTMENTS

Several studies have found that physicians who are able to prescribe naloxone in emergency department have, often, negative attitudes towards THN.¹⁴¹ Negative attitudes towards THN tend to correlate with having less personal experience with drug using populations.

Most researchers agree that greater (harm reduction-based) education of drug use and THN with medical professionals, as well as promoting THN through peak bodies is a useful way forward in the promotion and distribution of naloxone.

A US based study considered emergency departments as an underutilised area for (nasal) THN. The study investigated ED provider attitudes towards prescribing and dispensing THN, focussing on barriers and willingness. When assessing attitudes, 14/69 (20 per cent) felt that there was little they could do to help drug users, and 15/69 (22 per cent) had less respect for drug users compared to other patients they cared for. The factors most commonly influencing providers' willingness to prescribe were: 67/69 (97 per cent) if prescribing [nasal THN] was common in their ED and 65/69 (94 per cent) if there was strong evidence of mortality benefit. While only 17/69 (25 per cent) of physicians cited "lack of time in the clinical encounter" as a barrier to prescribing [nasal THN], 43/69 (62 per cent) endorsed lack of training as a barrier and 36/69 (52 per cent) cited lack of knowledge as a barrier to prescribing [nasal THN] from the ED. Concluded that the largest barrier to adoption of THN in emergency departments is education and training.

Reference:

¹⁴¹ Tobin, KE, Gaasch, WR, Clarke, C, MacKenzie, E & Latkin, CA 2005, Attitudes of emergency service providers towards naloxone distribution programs, *Journal of Urban Health*, vol. 82, no. 2, pp. 296-302

Dwyer, KH, Samuels, L, Moore, RL, et al, 2013, 'Physician attitudes and perceived barriers to prescribing nasal naloxone rescue kits in the emergency department', in American College of Emergency Physicians Forum, Seattle, United States, 14-15 October, published in Annals of Emergency Medicine.

CO-PRESCRIBING NALOXONE

One New Mexico based study was set up to assess the feasibility of co-prescribing naloxone with chronic pain medication. In a one year trial 164 patients were trained in THN and given kits yet no overdoses were reported among this cohort. The primary goal of this one-year study was to develop an efficient Universal Precautions model for co-prescribing of naloxone with chronic opioid therapy in the ambulatory clinic setting. This study illustrates a model that can be used to educate patients, caregivers, and an interdisciplinary team of health care professionals in an academic medical centre. Findings concluded that this could be a useful public health model.

The ambulatory co-prescribing of naloxone as Universal Precautions for all patients on Chronic Opioid Therapy (COT) can be adopted as a useful public health intervention. This study illustrates a model that can be used to educate patients, caregivers, and an interdisciplinary team of health care Professionals in an academic medical centre. This model can be imported easily into a primary care clinic or ambulatory specialty care setting, as the health care provider (e.g., physician, pharmacist, nurse, and naloxone educator) does not need to perform risk stratification and the tasks can be divided among the many health care team members.

Moreover, distribution of naloxone rescue kits and a short period of education on unintentional opioid overdose death for patients and their caregivers can change their perception of risk of unintentional opioid overdose death.

Reference:

Takeda, M.Y et al. 2016 Co-prescription of naloxone as a Universal Precautions model for patients on chronic opioid therapy—Observational study, Substance Abuse

OUTPATIENT PRESCRIPTION NALOXONE IN A COUNTY HOSPITAL EMERGENCY DEPARTMENT: A PILOT PROGRAM

This program is based in Chicago, USA. Participants are identified through routine taking of a patient's social history by emergency medicine residents in the Emergency Department. If patients disclose that they use opioids of some description they are asked if they are interested in THN and

related training. A 10-minute video and a live demonstration of drawing up the naloxone is presented. Following this they are given a prescription and certificate for their training. On giving both prescription and certificate to the hospital's outpatient pharmacy they get a free kit.

Challenges associated with pilot program:

- (1) time taken for staff to implement training (currently they volunteer their time);
- (2) most of their heroin users do not inject and some objected to intramuscular injection (of naloxone).

It was proposed that nasal naloxone may overcome these difficulties.

Reference:

Liu M., et al. 2013 Annual Meeting of the North American Congress of Clinical Toxicology, 2013. Atlanta, GA United States. Conference Start: 20130927. Conference End: 20131002. Conference Publication: 51 (7) (pp 718-719), 2013

COMMUNITY-BASED RECOVERY COACHES

An emergency department based in Rhode Island (USA), utilised community-based 'recovery coaches' (where available) to provide personalised education to participants, provide follow ups within 24-48 hours to patients after their ED visit, and refer patients to treatment where appropriate.

Reference:

Samuels, E 2014, 'Emergency department naloxone distribution: a Rhode Island Department of Health, Recovery Community, and Emergency Department partnership to reduce opioid overdose deaths, *Drug and Alcohol Disorders and Treatment*, vol. 97, no. 10, pp. 38-39

6. APPENDIX A: FULL LIST OF RETRIEVED GREY LITERATURE

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2. Benjamin, A, Davila, CA, Frost, T, Metzner, E, Motley, J & Roberts, E 2012, *Peer-delivered syringe exchange toolkit: models, considerations, and best practices*, Harm Reduction Coalition, New York.
3. Bradbury, G, Hunt, N & Morris, D 2014, *Models of community and peer-based overdose prevention services: Scotland, Denmark, Italy, Spain, Estonia and Lithuania*, Eurasian Harm Reduction Network, Vilnius.
4. Bradbury, G, Hunt, N & Morris, D 2014, *Overdose prevention services upon release from prison: best practices from Scotland, Denmark, Italy and Spain*, Eurasian Harm Reduction Network, Vilnius.
5. Bradbury, G, Hunt, N & Morris, D 2014, *Overdose prevention services upon release from prison: Estonia, Lithuania, Hungary, Poland and Romania*, Eurasian Harm Reduction Network, Vilnius.
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7. Branfield, F, Beresford, P, Andrews, EJ, Chambers, P, Staddon, P, Wise, G & Williams-Findlay, B 2006, *Making user involvement work: supporting service user networking and knowledge*, Joseph Rowntree Foundation, York.
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7. APPENDIX B: INDIVIDUALS AND ORGANISATIONS CONSULTED

1. Access Health Program, St Kilda; Paul Bourke
2. Barwon Health; Cath Peake
3. Burnet Institute; Paul Dietze, Margaret Hellard, Peter Higgs
4. Harm Reduction Victoria; Jane Dicka
5. Healthworks Footscray Cohealth; Moses Abbatangelo, Danny Jeffcote
6. Inner South Community Health; Lee McIntosh
7. Innerspace Collingwood Cohealth; Jay Jaggard
8. Monash Health; Theresa Lewislevy and Leanne Van
9. North Richmond Community Health; Penny Francis, Kasey Elmore, Ely Morrison, and Demos Krousos
10. sharc (Self Help Addiction Resource Centre); Jeff Gavin
11. SHARPS, Frankston, Peninsula Health; Sean Swift
12. VAADA; Sam Biondo and David Taylor