MY 1st 48 HRS OUT

Naloxone-on-Release

Guidelines for naloxone provision upon release from prison and other custodial settings

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Introduction

This work is a product of the project "My first 48 hours out – comprehensive approaches to pre and post prison release interventions for drug users in the criminal justice system".

The project, led by the Frankfurt University of Applied Sciences/Germany, received funding from the European Union for the period 2017-2018. It aims at addressing the gaps in the continuity of care for long-term drug users in prison and upon release, by supporting life-saving interventions for the prevention of overdoses and reduction of other risks related to drug use and for the establishment of a treatment path, which does not get interrupted upon release.

For prisoners with a history of drug use, in particular opioid use, the risks related to drug use, in particular overdose and death are extremely high in the immediate period after release due to high rates of relapse and lower opioid tolerance. Much still needs to be done in order to ensure that people with a history of drug use are sufficiently cared for, when released from prisons. Harm reduction measures need to be in place for ex-prisoners to be able to readjust to freedom without relapsing back into problematic drug use and extreme risk of fatal overdose when released.

The immediate time after release ("my first 48 hours out") is a critical time for action, when the cooperation between prisons, healthcare providers and NGOs is key in ensuring continuity of care and where targeted interventions can save lives from overdose and build a path towards engagement into further treatment and rehabilitation for people who use drugs.

Among other actions, the project wants to promote the implementation of life saving interventions in prison and upon release with specific reference to harm reduction, overdose prevention and the use of naloxone programmes.

This is a key priority to be addressed by both policy makers and practitioners in European countries. The current work aims at producing hands-on guidelines for policy makers and practitioners from prison health services on how to promote, initiate and manage interventions related to overdose prevention through naloxone programmes and related training and capacity building.

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In you are interested in translating/adapting the booklet (which the authors would welcome), please contact either Heino Stöver or Kirsten Horsburgh.

Frankfurt, Glasgow, 18 July 2018

Acronyms and Abbreviations

BLS - Basic Life Support

CNS – Central Nervous System

DRD – Drug-related Death

IM – Intramuscular

IN - Intranasal

NGO - Non-Governmental Organisation

NNP – National Naloxone Programme

OAT – Opioid Agonist Treatment

PGD – Patient Group Direction

POM – Prescription Only Medicine

SDF – Scottish Drugs Forum

THN – Take-Home Naloxone

WHO – World Health Organisation

Who are these Guidelines for?

These guidelines are relevant to prisoner healthcare policy makers, managers and practitioners involved in caring for people who use drugs and those likely to witness an overdose.

The objective of these guidelines is to assist in the reduction of opioid-related mortality within the first few weeks following prison release. Specifically these guidelines seek to:

- increase the availability of naloxone to people likely to witness an overdose when they are released from prison

- increase awareness of the identification of the signs and symptoms of an overdose and equip people with the skills to respond effectively

In order to achieve these outcomes, these guidelines will:

- inform prisoner healthcare policy makers of the benefits of naloxone-on-release from prison

- advise policy makers of the practical steps necessary to introduce naloxone-on-release

- inform programme managers of the benefits of naloxone-on-release and provide advice on implementation

These guidelines are intended to be straightforward and user-friendly, in order that organisations have a ready to use project plan that can be adapted to suit local requirements.

Opioid Overdose

Globally, overdose is a leading cause of premature death among people who inject drugs and the overwhelming majority of overdose fatalities involve opioids*. World-wide, an estimated 69 000 people die from opioid overdose each year (WHO, 2014).

Data collection, monitoring and pathology vary across Europe with between 6,300 and 8,000 drug-induced deaths reported each year (EMCDDA, 2016a). The true number is likely to be much higher.

Research has shown that the majority of these deaths are accidental and therefore preventable, with a large proportion of overdoses being witnessed by other people.

Opioids depress the central nervous system (CNS) and can contribute to life-threatening respiratory depression, particularly when taken in combination with other CNS depressants, such as benzodiazepines and alcohol.

Opioids affect the part of the brain that instructs the lungs to breathe, so when someone is experiencing an overdose the breathing is reduced until it stops altogether.

Non-fatal overdoses are also a major cause for concern as people can experience devastating and sometimes life-changing consequences due to injury and/or impairment, whilst also increases their chances of a future fatal overdose. It is estimated that in Europe, for every fatal overdose there are 20-25 non-fatal overdoses (EMCDDA, 2010). So even by using the lower estimate and reported deaths, that would be 126,000 every year.

**Opioids and opiates are used interchangeablly throughout this document*

What puts people at risk of overdose?

The main risk factors for overdose are:

Reduced tolerance –tolerance to a drug can decrease rapidly (often within a few days) when a person has ceased using a drug. Therefore high risk times for overdose will include release from prison/custody, discharge from hospital, following residential rehab or cessation of opioid agonist treatment.

Polydrug use–using a combination of different drugs (not necessarily at exactly the same time) and in particular a range of CNS depressants. Due to the action of long and short-acting drugs, people can still be 'mixing drugs' even if they are not taken on the same day in some instances. Long-acting drugs may be present in the body for several days.

Other factors such as poor physical health, mental health and social factors can also increase the risk of overdose.

What can be done to prevent an overdose?

Whilst these guidelines will focus on an intervention to prevent an overdose becoming a fatality, it is important to consider what could be done to prevent an overdose occurring in the first place.

It has been well researched and evidenced that treatment is a protective factor. Optimal dosing and duration of opioid agonist treatment must be provided in order to make an impact on reducing drug-related deaths (EMCDDA, 2016b).

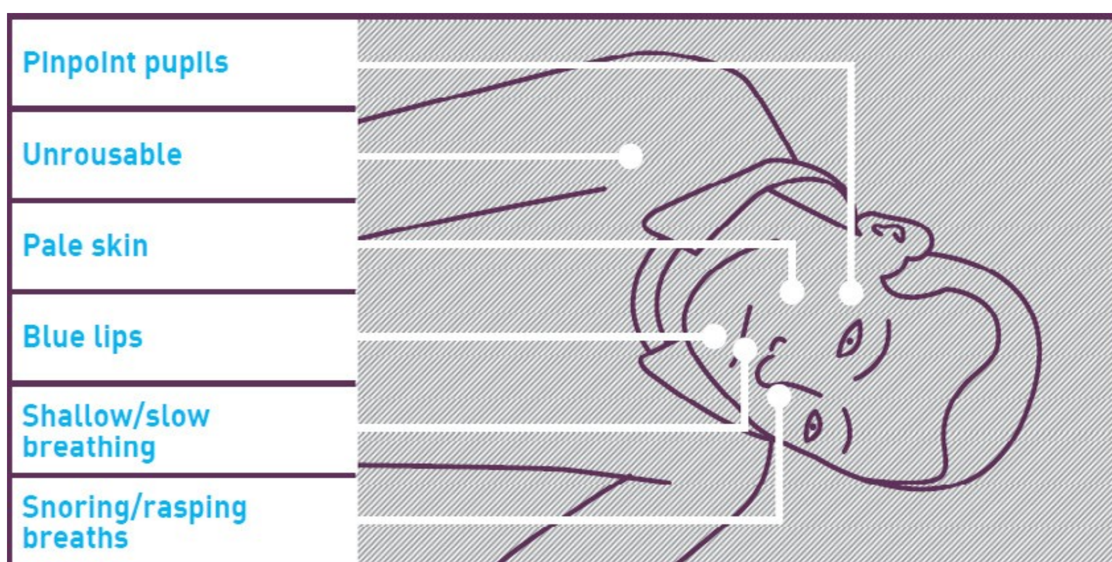
Providing information and having discussions about overdose risks are essential. It is important not to assume that people who have been using drugs for a long time have accurate information, as these assumptions often result in such conversations not taking place.

Who is likely to witness an overdose?

People most likely to witness an overdose are people who use drugs. Others will include family members, friends, staff working in drug services, homeless service staff, hostel staff, outreach workers, law enforcement…literally anyone who is in contact with people who use drugs - the list is endless.

What are the signs and symptoms of an overdose?

So many people die because it was not recognised that they were experiencing an overdose. Interventions to reverse an overdose are redundant if the overdose has not been identified. It is very common that people will assume that the person who has overdose is asleep because they appear to be snoring and therefore it is crucial that people are very familiar with the signs;



- Person is unresponsive
- Person has slow/shallow/rasping breathing (often mistaken for snoring)
- Person has pale skin and may have blue lips (cyanosis)
- Person has pinpoint (constricted) pupils (indicates that opiates have been consumed) however opiate overdose should not be ruled out if pinned pupils are not present

In the majority of cases, death will not occur instantaneously. Many deaths happen two or three hours after drug use. Only one-quarter of deaths happen immediately after drug administration. This timeframe provides an opportunity for intervention.

The majority of witnesses actively intervene to address the emergency, but many of their actions tend to be incorrect and ineffective (slapping their collapsed companion, walking them around, etc.). In research interviews with people who had experienced or witnessed an overdose, only half had called for an ambulance; their principal reasons for not doing so were fear of police involvement and belief that they could handle the situation themselves (Wakeman et al. 2009).

Harm reduction advice for people who use opiates

- Be aware of your tolerance (if you haven't used for a while) and take a 'test dose' first
- Consider smoking rather than injecting
- Avoid mixing drugs (including prescriptions and alcohol)
- Don't use alone
- Make sure naloxone is available and that everyone there knows where it is and how to use it
- Look out for the signs and symptoms of an overdose
- Call for an ambulance if someone is in trouble

What is Naloxone?

Naloxone is a medication that reverses the effect of opioids. In an emergency overdose situation it can be a lifesaver.

The medication itself has been around for over 50 years, is on the World Health Organisation's (WHO) list of essential medicines and more recently was recommended in WHO guidelines for the community management of opioid overdose. The practice of putting naloxone in the hands of people most likely to witness an overdose (people who use drugs) began in the 90's.

How it works

Naloxone works by temporarily displacing the opioids from the receptors in the brain to reverse the breathing difficulties being experienced by the person who has overdosed (EMCDDA, 2016a). When administered by intramuscular injection this only takes a few minutes although several doses may be required depending on the person's response and the opioid involved.

It is a 'competitive antagonist' which means that it competes with opioids for the receptors and then blocks them temporarily. So it does not cause any kind of 'high' or intoxication, its only job is to reverse the effects of respiratory depression caused by opioids.

Opioids include methadone, codeine, tramadol, fentanyl and morphine amongst others, so it is not only for use in suspected heroin overdoses.

If the person who has overdosed is physically dependent on opioids they may experience acute withdrawal syndrome following naloxone administration, the risk of which increases with the amount of naloxone that has been administered.

Naloxone is very short-acting and the effects will begin to wear off after 20-30 minutes, after which the opioids will re-attach to the receptors. It is very important that the person does not use any further drugs while the naloxone is active as when it wears off they would likely overdose again.

Naloxone is an extremely safe medication.

When it should be given

Naloxone is for 'suspected' opiate overdose not confirmed. If there are signs of an overdose, it is perfectly safe to administer naloxone to someone even if it turns out they have not consumed opiates, although it would be ineffective in reversing the effects of any other drugs such as alcohol, benzodiazepines or cocaine, although they may contribute to an overdose.

Formulations

In Europe, naloxone has only been licensed for intramuscular, intravenous and subcutaneous use until recently. A licensed intranasal formulation has now been approved for use in the European Union, similar to the ones that have been introduced in the United States and Canada. It is a nasal spray (Nyxoid) available in single-dose containers (1.8mg) and the recommended dose is one spray into one nostril. At the time of writing, it is not currently being used in any European country and is not yet available in the UK.

In some countries, such as Norway and Germany, a nasal atomiser is attached to a pre-filled syringe of naloxone 1mg/ml and administered intranasally off-license rather than by injection.

Ampoules or vials and pre-filled syringes of naloxone hydrochloride are available in different concentrations: 0.02 mg, 0.4 mg and 1 mg per 1 ml vials, 2 mg/1 ml, 2 mg/2 ml, 2 mg/5 ml prefilled syringes, and a 4 mg/10 ml multi-dose vial.

Dosing will depend on which product is chosen but in most cases 0.4–0.8 mg is an effective dose. It is important to provide sufficient naloxone to supplement the initial dose, as necessary (WHO, 2014).

In France, the nasal spray that has been adopted off-license is a dose of 0.9mg/0.1 ml administered in each nostril, repeated after few minutes, with a total of 4 x 0.9mg doses.

In the UK, naloxone is provided in a 2mg/2ml pre-filled syringe with two needles for intramuscular administration. Doses of 0.4mg are given every 2-3 minutes until the person becomes responsive.

Legal Considerations

The legal situation varies across Europe and gives an unclear picture. It has been described well in the EMCDDA publication 'Preventing opioid overdose deaths with take-home naloxone'.

In the EU, naloxone is currently only licensed for injection, meaning it is usually a prescription only medicine, which is why the legalities can create obstacles for take-home naloxone programmes.

The main challenges are that possession or use of naloxone could be considered an offence in some countries and there is also some concern regarding liability should the person who has overdosed come to additional harm or if they were to die following the administration of naloxone.

Currently, several European countries manage this with a 'legal code' that protects first responders.

These obstacles may be alleviated with the introduction of licensed intranasal products in the near future.

Example from France

The availability of naloxone for people who use drugs in France was made available in two phases:

Phase One

Firstly, a Temporary Cohort Use Authorisation (ATUc) from the French National Agency for the Safety of Health Products (ANSM, the French drug agency) for the NALSCUE® product (naloxone nasal spray from Indivior), was authorised on 5th November, 2015 and was made available from 26th July, 2016.

The ATUs allow a therapeutic treatment of which efficacy and safety of use are strongly presumed, to be dispensed in a controlled manner for a defined population with the authorisation of the ANSM, pending a marketing authorisation that the pharmaceutical company undertakes to request.

The ATUc allows treatment to be made available before the marketing authorisation, but with inclusion by a doctor, delivery of treatment by a hospital pharmacy, and provision of medical follow-up data to be transmitted by the prescriber to the pharmaceutical company, which communicates them to the ANSM.

During the ATUc, NALSCUE® could be provided in all specialised addicto-

logic care settings (medico-social settings called CSAPA, the most common specialised settings in the community with more than 450 centers throughout France), emergency services, hospital addiction unit, Addiction Care and Liaison Teams (ELSA) in hospitals, penitentiary health units as well as by centres and structures with mobile care teams for people in a precarious or excluded situation managed by non-profit organisations.

ATUc limitations: Harm reduction settings (called CAARUDs in France: Centres d' Accueil et d' Accompagnement à la réduction des risques pour les usagers de Drogues) are not authorised for regulatory reasons within the framework of the ATUc to dispense naloxone despite their crucial role in preventing harms among active drug users. The main reason is that they are not medicalised and usually only provide harm reduction tools and not medical treatments.

Phase 2

Within the framework of the marketing authorisation: The ANSM issued a marketing authorisation for NALSCUE®(naloxone 0.9mg/0.1 ml) on 28th July 2017. Discussion on the price of the product is ongoing.

Once the discussion on the price of the drug and reimbursement rate is complete, NALSCUE® will then be available as a non-mandatory prescription treatment, with dispensing to patients who have received specific training in its use. This is already the case for patients who have been included in the ATU NALSCUE® protocol, but training of users and professionals must continue.

In addition to the previous settings, CAARUDs will be allowed to deliver naloxone to the people they follow, provided that staff are trained to provide tailored information for people who use drugs, their relatives and peers.

In the UK, a change was made to the Medicines Act in 2005 which added naloxone to a list of medications that can be administered, by injection, by anyone for the purpose of saving a life. Because of its Prescription Only Medicine (POM) status it is not available over the counter and was initially supplied using a Patient Group Direction (PGD) or in some cases a prescription however, due to a regulation change in October 2015, it is now much more widely available and accessible without the need for a PGD or prescription.

PGDs, similar to Standing Orders used in some countries, are written instructions (signed by a doctor and a pharmacist) to allow the supply or administration of POMs by nurses and pharmacists without the need for an individual prescription from a doctor.

Naloxone can be supplied to anyone who is likely to witness an overdose which includes family members, friends, staff working in services in contact with people who use drugs and most importantly, people who use drugs.

The supply is no longer restricted to nurses/pharmacists and can now be provided by anyone working in a drugs service.

In Italy, from 1991, the practice of distributing THN was initiated when doctors took the responsibility to allow the harm reduction staff to do so in response to the rising numbers of drug-related deaths (Ronconi et al. 2016).

Naloxone was then formally classified as an over-the-counter drug in 1996 by the Minister of Health. This means it is now sold in pharmacies without the need for a prescription, available to anyone and pharmacies are obliged to have it available as it is a life-saving medication.

The legislation in the Italian Penal Code is also very clear about lay people being first responders. This is covered by two articles – emergency situations and omission of first aid. Essentially, lay people are covered legally by administering naloxone to someone who appears to be in a life-threatening condition and may indeed face prosecution for not assisting someone who appears to be in danger.

Literature Review

There are a limited number of published papers on the subject of naloxone-on-release within European countries. A mapping review conducted (Horton et al. 2017) showed that the majority of papers looked at attitudes towards naloxone-on-release and were mainly from the USA or the UK.

The information below has been taken mainly from these limited published papers and from the EMCCDA report (EMCDDA, 2016a) and also gives a brief highlight of community distribution in Europe.

Norway

The community intranasal naloxone programme, commenced in Oslo and Bergen in 2014, has previously been unable to implement on a large scale within the prison setting. As the programme expands, emphasis on establishing within prisons is a priority. In Norway the programme provides a pre-filled naloxone syringe (2mg/2ml) with a nasal atomiser rather than needles for injection.

A study conducted inside prisons was completed to assess the impact of brief overdose prevention training. It assessed the knowledge of prisoners in Oslo pre and post naloxone training (Petterson and Madah-Amiri, 2017).

Participants were found to have a high baseline knowledge of risk factors, symptoms and care regarding opioid overdoses. However the brief training significantly improved knowledge, particularly in relation to naloxone.

They concluded that the need for overdose prevention programmes is critical and that naloxone training provided in the prison setting may improve the ability of inmates to recognise and manage opioid overdoses after their release.

Estonia

In Estonia, as well as having a community based programme (launched in 2013), from 2015 naloxone began being issued by medical departments within prisons. These prisons organise training for inmates with previous experience of IV opioid use before they are released from prison and upon release, give them a pre-filled naloxone syringe kit to take home.

From June 2015 to the end of 2016, a total of 107 inmates received relevant training in Viru Prison, Harku and Murru Prison, and Tartu Prison; 85 pre-filled naloxone syringes were issued to inmates upon release.

England, UK

In 2008, the UK Medical Research Council awarded funding for the N-ALIVE pilot trial. Any prison inmate of at least 18 years of age, with a minimum duration of imprisonment of 7 days and a history of injection heroin use, was eligible for participation in

the trial, which started in May 2012. Participants from 16 prisons in England were randomised to participate in the N-ALIVE trial.

Upon release from prison, those randomised to the take-home naloxone arm would receive an N-ALIVE wallet containing a pre-filled naloxone syringe and an instruction leaflet, as well as a DVD containing video instructions on overdose management and naloxone administration.

Study subjects in the control group learnt, at the point of their release, that the N-ALIVE wallet given to them contained no naloxone.

Randomisation to the N-ALIVE trial ended on 8 December 2014, partly due to the evidence from Scotland's national naloxone programme (EMCDDA, 2016a).

Ireland

Commencing in 2015, 31 individuals were trained as trainers with close to 600 taking part in multi-agency training sessions for the naloxone demonstration project (Health Service Executive, 2016).

95 prescriptions of THN were issued during the project by 6 GPs in Dublin and Limerick.

5 potentially fatal overdoses were prevented with THN which was administered on 4 occasions by staff and once by a peer.

The Irish prison service participated in the roll out of the training and delays regarding prescribing were experienced but resolved towards the end of the project.

Denmark

Intranasal naloxone distribution started in 2013 in Copenhagen, Aarhus, Odense and Glostrup. As of 2014, 121 people who use drugs had received overdose prevention training and THN kits (EMCDDA, 2016a).

THN is provided to people who use drugs, family members, friends and staff working in services. Training is provided on overdose prevention and management before people are provided with a THN kit.

The kit is a 2mg/2ml pre-filled syringe with a separate nasal atomiser. There are 5 doses of 0.4mg with instructions to administer the first 3 doses intranasally and the remaining two by intramuscular injection.

Germany

"Fixpunkt" Berlin began distributing THN in 1999 but the project did not secure funding after the pilot phase in 2002. THN did, however, continue to be provided in lower numbers following the pilot (Dichtl et al. 2018; Dichtl and Stöver 2015).

Currently there are approximately 10 initiatives of NGOs providing THN, and also some self-help organisations. However, no THN programme is focusing on the period of release from prison.

THN is now being discussed widely in Germany as well as the development of a network in order to improve the provision of THN (coordinated by Akzept e.V.; see www.naloxoninfo.de).

Italy

THN has been available over-the-counter in pharmacies in Italy since the late 80s and was distributed as early at 1991 to people who use drugs, their families and friends but has never been formally evaluated.

THN forms part of the overdose prevention strategy and is now distributed from 57 low-threshold harm reduction services although availability can vary regionally, with notably the south and the islands lacking in this provision. The majority of THN supplies are from drop-ins and mobile needle exchanges. As well as being provided by workers in these services, there is also a strong peer-to-peer education and supply network in operation (Ronconi et al. 2016).

Despite THN being available in pharmacies, the pharmacists themselves do not play an active role in distributing it to people who use drugs and this is seen as a shortfall in the programme.

In 2015, of the 57 services that distributed THN to their clients, 2 did not provide data. The 55 services for which activity data is known, showed a total volume of 14.999 vials distributed, an average of 272 vials per year.

There are little to no harm reduction services provided in prisons in Italy and this is recognised as an area where THN distribution would be valuable.

This research from Italy derived a number of conclusion and recommendations. The ones specific to the Italian context are noted below.

OPERATIVE

- The current regulatory framework is clear and sufficient
- Every service can and should distribute naloxone
- Provide incentive for the peer support approach, collaboration between peers-services and support PWUDs associations
- Initiate programmes aimed at families
- Adopt THN in prison and post-prison contexts

POLICY

- To have an up-to-date policy and action plan on drugs
- To release guidelines for Harm Reduction
- Include THN in the LEA- Essential levels of Assistance

RESEARCH

- Include THN in the institutional monitoring system
- Develop qualitative research, change perception about people who use drugs
- Develop evaluation studies for the processes and outcomes of THN
- Greater synergy between information systems and the death registries to monitor cases of overdose

Spain

Barcelona began formally distributing THN in 2008, although there were reports of this happening informally since 2001.

The formal programme commenced in 2008 and THN is now provided to people who use drugs from a broad range of services including drug treatment services, drug consumption rooms and detox centres.

Initially there was a financial incentive for people who use drugs to attend training. By December 2013, 5830 THN kits had been supplied with 40% reporting having used it on someone.

Challenges noted by the programme coordinators include attitudinal barriers from abstinence-focussed services, limited carriage of naloxone kits and a lack of provision via the prison service (EMCDDA 2016a).

UK

Availability of naloxone in England is improving and is provided in 138 of 151 local authority areas. However in a recent report (Release, 2017) analysis of the coverage of THN in each locality was variable;

Out of 151 local authorities, 117 provided details on the number of take-home naloxone kits given out in the 2016/17 financial year. Among these:

- Nationally, an average of 12 take-home naloxone kits were given out for every 100 people using opiates (equivalent to only 12% coverage);
- Coverage was 0% in 18 areas (including the 13 that did not provide take-home naloxone);
- Coverage was between 1% and 20% in 72 areas;
- Coverage was between 20% and 49% in 26 areas.

Meanwhile, Wales now has a national programme that commenced in 2009 (as a pilot) and up until March 2017, 15037 kits had been supplied to 6302 unique individuals. It has been reportedly used 1654 times in overdose situations (Morgan and Smith, 2017).

There are six male-only prisons located within Wales, three of which provide THN to individuals identified at risk upon release. During 2016-17 distribution of THN was successfully implemented within HMP Eastwood Park in Gloucestershire (serving as Wales' closest female prison) and police custody suites within Wales.

The Scottish Model

Context

Rates of drug-related deaths in Scotland are among the highest in Europe. In 2016, 867 people lost their lives to preventable overdose deaths, the majority of which were accidental (National Records of Scotland, 2017).

In response to the rising number of opioid-related deaths, the Scottish Government introduced a National Naloxone Programme in 2010, which was launched in 2011.

Scotland has a population of approximately 5.2 million people with 14 Health Boards, 15 Prisons and 30 Alcohol and Drug Partnerships. All 14 of the Health Boards participate in the take-home naloxone programme and all 15 Prisons are involved in supplying naloxone to people on-release.

There are around 61,500 people with problematic drug use in Scotland and in the region of 23,255 of those are known to services. Between 22-25,000 people receive methadone prescriptions.

Every August, the National Records of Scotland report is published which details the number of people who died from a drug-related death the previous year, their ages, demographics and the drugs that were implicated in the deaths. From the 2016 figures, the average number of people dying in Scotland every year is 659 and the average age is 41.

The main drugs involved in the deaths are consistently heroin, methadone, benzodiazepines and alcohol. In 2016, opiates were implicated in, or potentially contributed to, 88% of the deaths.

Around 6 months* after the NRS report, Information Services Division (ISD) Scotland publishes the Drug Deaths Database report that provides a more detailed picture of the individual circumstances surrounding the deaths (Information Services Division 2016a).

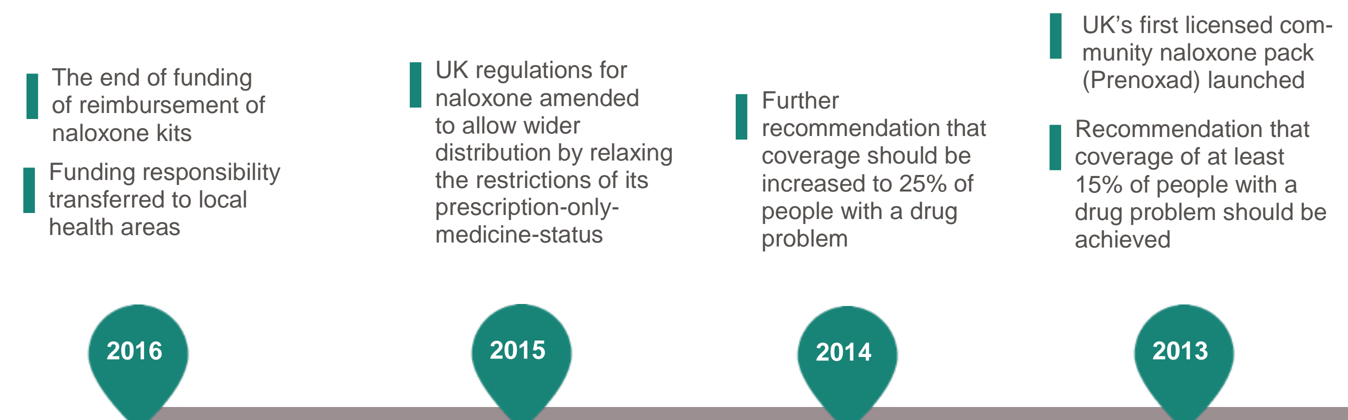
**This has now been changed to a biannual report from 2016.*

There are many common themes emerge from this;

- There are often several hours between the overdose and the death
- The person is likely to have had a previous non-fatal overdose
- A combination of drugs have been taken
- Witnesses are present
- The person is an older (35-44 yrs) drug user with a long history of problematic drug use
- The person is not in treatment, but in a large number of cases has been in treatment within 6 months prior to their death

Given that two of the main drugs involved are opioids and that in most cases witnesses are present, it makes sense to get naloxone in to the hands of those most likely to witness an overdose.

History



For the first time, the prisons were issued with a separate target (previously the target had included community and prison figures together). The prison target was an annual rather than cumulative target, based on the number of prisoners who test positive for opiates at reception and the average number of liberations each prison has on an annual basis. They are expected to supply a minimum of 25% each year.

This was an important development for the consideration of a take-home naloxone programme as now anyone can legally administer naloxone to anyone for the purpose of saving a life in an emergency.

2006

Multi-agency factfinding trip from Glasgow to the Chicago Recovery Alliance. USA

2007

Glasgow and Lanarkshire naloxone pilots launched

2009

NHS Highland introduce a pilot programme

2010

National Forum on Drug-Related Deaths recommend the development of local THN programmes

Scottish Government announce rollout of fully funded community and prison National Naloxone Programme

SDF recieve funding to provide training element of national programme

National Naloxone Advisory Group established and develops a National Patient Group Direction to allow the supply of naloxone

2011

Lord Advocate produces guidelines to allow the supply of naloxone to extend to staff working in services

2012

First naloxone monitoring report published by Information Services Division Scotland - reported that there had been 3445 THN kits supplied during 2011/12

First two Naloxone Peer Eductaion networks trained and established

The Prison Programme

A major focus of the national programme was to ensure that naloxone was provided to prisoners on-release because of their elevated risk of overdose and drug-related deaths within the weeks following liberation (Bird and Hutchison, 2003).

On average, 7800 individuals are incarcerated within Scotland's prisons daily (Scottish Government, 2015) and a third of those entering prison test positive for opiates at reception (Scottish Prison Service, 2014).

Training is offered to people with a history of opiate use, and is provided by NHS staff, during their sentence, often within the 6 weeks prior to release. A naloxone kit is placed in their personal belongings by reception staff which is handed to people at the point of release (Horsburgh and McAuley, 2017).

In addition, Scottish Drugs Forum has delivered 'peer education' training to numerous groups of prisoners across Scotland to allow them to train others within the prison. This approach has reportedly increased the acceptability of naloxone within the Scottish prison estate and undoubtedly assisted the staff to increase the number of kits provided.

In the latest national naloxone report, a cumulative total of 4,343 THN kits were issued in prisons in Scotland from 2011/12 to 2015/16 (Information Services Division, 2016b).

More recently, training was provided to almost 300 night staff prison officers to give them the skills to identify an overdose and respond with naloxone. This is currently in the process of being approved by the Scottish Prison Service and awaiting a launch date. This training took place due to the fact that there is no nursing cover overnight in Scottish prisons and by providing officers with naloxone this will save valuable time while waiting for an ambulance to arrive.

Practical steps

The aim of the prison naloxone programme is to train prisoners in overdose prevention, intervention and naloxone during their sentence and to provide them with naloxone-on-release. It is delivered by NHS staff and peers, facilitated by the Scottish Prison Service.

There are many steps along the 'prisoner journey' through their sentence where they have access to training. The steps below describe some of the potential barriers and solutions to each phase.

Reception

This is where the prisoner is checked in when they arrive at the prison and a drug test will be taken by health care staff. If they have a positive test for opiates they should be informed of the naloxone programme and their interest noted in their file. If the person declines, they will be approached again at a later date.

Barriers:

This is not always the best time to introduce an intervention that will only be available on release. The person will undoubtedly have mainly other things on his mind.

There is a change that they are not informed of the programme, it is not recorded or that they are not followed up.

Solution:

Ensure there are multiple opportunities for training throughout their sentence.

Induction

The induction programme is offered to all prisoners within the first few days of their sentence. In some establishments it is also peer delivered and in many the naloxone programme is included in this information session. Interest in the training is again noted at this point by staff or peers.

Barriers:

Induction is not mandatory so people may not attend. Their interest in the training may not be noted.

Solution:

Ensure there are multiple opportunities for training throughout their sentence.

Training

This is often delivered 6 weeks prior to liberation, in combination with other pre-release programmes.

Barriers:

These programmes are not mandatory so people may not attend. They also may be released earlier than expected and therefore miss this opportunity.

Solutions:

Ensure there are multiple opportunities for training throughout their sentence (the length of time prior to release is not the most important factor).

Referrals

During the person's sentence, they can also self refer for training at any point – they may have seen a poster, read a leaflet, been told about it by a peer or by a family member/friend at a visit.

Training delivery

Initially this was designed to be delivered in a group setting by two staff members.

Barriers:

Organising trainers and participants to be in the same place at the same time was problematic.

Prisoners had competing priorities – work, gym, visits etc.

Prison officers were required to escort people to training which reportedly did not always happen due to prisoners refusing on the day.

Staff shortages or availability was an issue.

Groups are not always suitable in a prison environment, particularly with the subject of overdose which can be emotive and the environment can be intimidating.

Solutions:

Training is now mostly delivered as a brief intervention over 10-15 minutes.

One member of staff or a naloxone peer trainer delivers this – can be done in clinics, as part of other appointments or on the halls.

The nursing staff then delivers the naloxone kit to the reception area to be placed in the person's valuable property (with their mobile phone etc.).

Barriers:

The timing for this training can be problematic – if someone is trained a year before they are released, the kit needs to be put in their valuable property nearer that time. People are often released early from court before there has been a chance to put the kit in their valuables.

Reception staff are not always informed of what naloxone is and may not realise the importance of ensuring the kit is put in the valuables.

Solutions:

It is imperative that prison officers are given awareness sessions on naloxone. Not only so that they know what it is themselves but also so that they are able to answer questions from prisoners and encourage them to leave with it.

Find a mechanism to ensure that the kit is placed in the valuables in plenty of time prior to court appearances, early release etc.

Release day

The person collects their valuable property as they leave the prison.

Barriers:

The kit has not been placed in the valuables. The person is unlikely to wait until it can be delivered at this point.

Unnecessary attention is drawn to the kit by the staff and the person refuses to take

it. This may be because the person has said they will no longer be using drugs and taking naloxone may be seen as contradictory. Or they may not wish to be seen as someone who uses drugs by other people in the vicinity.

Solutions:

Ensure the kit is securely in the valuable property prior to release.

Involve peers at this stage – a great example was in one of the Scottish prisons where naloxone peers were given a job that involved being at the reception area to ensure people left with their kits.

The overwhelming majority of barriers have been operational. Systems and standard operating procedures should be put in place to minimise these types of barriers.

Peer Education

Scottish Drugs Forum introduced an innovative Naloxone Peer Education Programme in 2012, which continues to be implemented across Scotland to date (Scottish Drugs Forum, 2012).

Peer educators are recruited from a variety of services in the community, most have a history of using drugs but in some cases, they are family members who have lost a son or daughter to an overdose.

Peer educators are trained by SDF over four days focusing on different components of the skills and knowledge required to carrying out brief interventions in the community and are supported by face-to-face meetings on a monthly basis.

Local support is provided by a named service lead in the area, with meetings planned on a regular basis with peers to discuss any training or personal issues that arise. Support as a group or 1-1 is then offered to people depending on the issues raised. Peer educators have, to date, provided thousands of hours of their own time to help increase the awareness and supplies of naloxone throughout Scotland with several thousand people now having been trained by a naloxone peer educator.

In 2015, new regulations regarding the supply of naloxone, means that people employed or engaged in the provision of drug treatment services can provide it to anyone who may witness an overdose without the need for a prescription. This important change means that in addition to nurses and pharmacists, other people undertaking roles within drug treatment services can also make supplies of naloxone, such as volunteers.

In August 2017, the UK's first naloxone peer supply model was launched in Glasgow (Scottish Drugs Forum, 2017).

It is hoped that the volunteers will contribute to increasing the availability of naloxone within the community so that it is more likely to be present when an overdose occurs, and the project will also provide additional skills and opportunities for the volunteers themselves.

The newly established group will first target Recovery Communities in Glasgow, then move to supported accommodations, residential and community programmes, as well as aiming to reach people at risk in the streets of Glasgow who may be homeless or roofless and not currently engaged with services. Through adding the supply element to the current peer naloxone training, the model aims to be more effective in reaching these at-risk populations.

The Peer Supply Model will be evaluated and if deemed a success, the model will be implemented in other Health Boards across Scotland.

Within the first 3 months of operating, peers had supplied over 300 take-home naloxone kits to people likely to witness an overdose.

Effectiveness

The primary outcome for the effectiveness of the Scottish naloxone programme was to show a reduction in the number of opioid-related deaths within 4 weeks of liberation from prison.

These deaths decreased by 36% from 9.8 to 6.3% during the evaluation period. It was estimated that having issued nearly 12,000 naloxone kits during 2011–13, Scotland's national naloxone programme may have prevented 42 prison release opioid-related deaths.

The secondary outcome was to show a reduction in the number of opioid-related deaths following hospital discharge and in contrast, the national naloxone programme had little apparent effect in this area (Bird et al. 2016).

It should be noted that hospitals were not targeted as an essential naloxone supply route in the same way that prisons were. There are only a small numbers of hospitals across Scotland currently providing take-home naloxone via the hospital setting. Unfortunately over the course of the programme, drug-related deaths as a whole have continued to increase.

Naloxone has been used thousands of times to reverse potentially fatal opiate-related overdoses so it is realistic to suggest that the number of deaths may have been much higher had naloxone not been available.

Depending on our definition of effectiveness, there are other ways to look at the impact of the Scottish programme.

From a treatment provider perspective – the introduction of the national programme made it more likely for practitioners to have conversations with people attending their service about the risks of overdose and how to respond. In a culture of what is often seen as 'punitive' type services, the programme offered a way to break down barriers and improve relationships with the client group.

Providing naloxone is a very powerful message, indicating that it matters whether the individual lives or dies.

The programme has succeeded in normalising the provision of naloxone to people who use drugs, their family members and now anyone else likely to witness an overdose, and is addressing stigma by doing so.

Despite all of the above, naloxone is not present where all overdoses are occurring and we need to ensure a much better coverage to improve this.

Areas for Improvement

Police Scotland is not currently involved or accepting of the use of naloxone by their staff. Incidentally, police are very often first on the scene when an overdose occurs and therefore in a prime position to respond effectively with naloxone. One of the reasons used to justify this lack of acceptance is due to the product being injectable. In light of this it is hoped that in 2018 we will have access to an intranasal formulation which will assist in these discussions, which are still currently ongoing regardless.

General Practitioners are well placed to be prescribing naloxone to people who may not be in contact with traditional drug services as many GPs prescribe opiate replacement therapy. It has been difficult to engage GPs in the programme, despite what previously appears to have been a potential will for them to do so (Pflanz-Sinclair et al. 2013).

The Scottish Ambulance Service is another organisation that could have a key role in the distribution of naloxone when they attend non-fatal overdoses. Many people do not go with the paramedics to hospital and can be at risk of further overdose. This is a perfect opportunity to offer some brief training and provision of naloxone kits.

Due to the regulation change in 2015, 3rd sector organisations can now provide naloxone, however many areas are not taking advantage of this change.

Prison supply of naloxone has been variable across the estate and therefore could be better embedded to be more effective.

Finally, the role of peers in the programme could be broadened to have more supply networks across the country which would greatly enhance the distribution to people most at risk.

Implementation Guidance - Policy Makers

The following guidance is based on the experience and learning from the Scottish National Naloxone Programme.

Investigate the legal situation for providing naloxone to people who use drugs and others likely to witness an overdose.

Identify project lead – this person will be responsible for managing and coordinating the implementation of the THN programme.

Identify key partners – could include the following; relevant govt dept, prison headquarters, prison operations, prison healthcare, prison pharmacy, data collection dept, people who use drugs, prisoner rep, family support.

Establish Working Group – this group will have multi-agency responsibility for the strategic coordination of the programme.

Determine funding stream – main cost will be for the product itself and consideration should be given to additional staff required for the implementation phase (project lead and training leads).

Identify suitable product – this should be in line with the legal framework of each country and affordability based on budget.

Devise data collection model – consideration should be given to how this can be done in the least time-consuming manner for practitioners (example of Scottish system in appendix). Data should be collected on number of kits distributed, whether it is a first supply or a repeat supply (if it is a repeat supply, what is the reason for this – used on someone, used on themselves by another, lost, confiscated, other), demographics. You may also wish to collect 'postcode' data to identify the area the person receiving THN will be released to, if known.

In Scotland, this data is provided to managers on a quarterly basis which allows for targeted interventions if the supply rates are low.

Establish supply mechanisms – consider the easiest method for opportunistic, unplanned care. Ideally a framework will be in place with minimal restrictions.

Continues over page

Identify ‘master’ trainer – this person(s) will be responsible for training the workforce as trainers. They should have an excellent knowledge of overdose prevention, intervention and naloxone. They should read good quality information and receive some training themselves to ensure they are fully equipped to deliver.

Devise training plan–identify those who will require training. The master trainer(s) should deliver ‘training for trainers’ to staff who will be training those likely to witness an overdose. Anyone can be trained as a trainer and can then also go on to deliver awareness sessions. The main ‘training for trainers’ should remain the responsibility of the master trainer to ensure continuity and quality.

Design peer education model – it would be sensible to have a ‘go-to’ model that could be adapted to local needs if necessary.

Produce materials – leaflets and posters for awareness raising of the programme are important.

Communication – ensure that all partners, particularly those who will have a role in the delivery, are aware of the programme from the development stage so that people can prepare and feel part of it.

Deliver training – training should be delivered once all of the practical processes are in place so that once a staff member has received training they can immediately start to deliver training to people likely to witness an overdose.

Monitor programme – the working group should continue to meet once the programme is up and running to address any issues that arise and monitor its progress.

Implementation Guidance - Practitioners

Identify lead – this person will be part of the staff team and responsible for coordinating the programme inside the prison by ensuring barriers are addressed, data is being collected and that the programme is being delivered as intended.

Identify lead for peer involvement – this will be a different person from the overall lead. It should be someone who is already involved in delivering programmes to prisoners and has a good reputation and relationship with prisoners. In Scotland, this was always an officer from the Scottish Prison Service rather than the health service.

Standard Operating Procedures (SOPs) – SOPs should be in place detailing all of the operational aspects of the programme such as who will deliver training, how it will be recorded, where the naloxone will be stored and responsibilities for ensuring it is provided on release.

Paperwork – should be in place for recording training and monitoring data.

Materials – leaflets, information cards and posters should be circulated around the prison and also provided to people following training. Consideration should also be given to the provision of certificates to those who complete the training.

Devise a staff training plan – identify key staff to be trained as trainers and coordinate attendance for training.

Attend staff training – all staff identified must attend the 'training for trainers' course delivered by the master trainer(s) before training people likely to witness an overdose. Following this, staff should be in a position to start training people straight away while the knowledge is fresh.

Identify prisoners for roles as peer educators – tips and guidance for this are provided in the section in chapter 10.

Train peer educators – lead for peer involvement should arrange training for peers based on the programme that has been developed in advance.

Deliver training – this should be opportunistic, brief and delivered in a variety of settings. It should be normalised and discussed at any opportunity. It may also be reasonable to have some small group sessions but this should not be the main source of training.

Naloxone Training

Staff Training

Naloxone Training for Trainers (to be delivered by master trainer)

This course should provide an overview of drug-related deaths (DRDs) nationally and locally with an emphasis on overdose prevention, intervention and naloxone.

It should explore the causes of DRDs, risk factors, high risk times, myths and how to identify the signs and symptoms of an overdose.

There should be a focus on naloxone, its actions, kit assembly and administration with specific attention to the inclusion of naloxone in basic life support.

The course should also include an element of adult learning and teaching, providing people with the skills to deliver group sessions and brief interventions.

Following the course workshops and practical skills training, participants should feel confident in identifying an overdose and intervening with naloxone which may be available for use in an emergency situation within the prisons.

Participants should also be in a position to offer training on overdose and naloxone to people likely to witness an overdose, to encourage the uptake of take-home naloxone on release in accordance with the THN programme.

Learning Outcomes

By the end of the session participants should;

- Have a clear understanding of the evidenced based overdose prevention and naloxone messages
- Clearly identify and communicate the observable signs/symptoms of a depressant overdose and respond accordingly
- Be equipped with the skills and knowledge to manage an overdose emergency and answer questions from prisoners on naloxone
- Have a much greater understanding of the THN Programme and its importance to assist in the reduction of DRDs
- Feel confident to deliver THN training to people likely to witness an overdose.

Aimed At

Staff working in prisons

Duration

Example from Scotland: Training for Trainers (T4T) was initially delivered over 2 days but often reduced to 1 day due to restrictions of staff attendance. It is now delivered over 1 day but only due to the fact that SDF has other courses on DRDs that duplicate some of the T4T content.

Awareness Sessions

Generally delivered over 1.5-3 hours and are aimed at those who may need to respond to an overdose but will not be training people in the use of naloxone.

Awareness sessions are a condensed version of the T4T, without the adult learning and teaching element.

Peer Education Model

Peer Naloxone Education Programme

(Training prisoners as trainers to deliver the intervention to others within the prison)

In Scotland, this is a four day community based course (usually delivered over 3 weeks) followed by six meetings (4-6 weekly) to consolidate learning.

In the community, it would be as follows:

Day One: Drug Awareness, with a strong emphasis on attitudes, values and stigma.

Days Two and Three: Naloxone Training for Trainers course (as staff training).

Day Four: Theory and Practical, exploring the benefits and challenges of peer education plus practical strategies for delivering training.

This training not only enables peers to deliver naloxone training but also provides them with valuable skills to support their own personal development.

In the prison environment it has been condensed to meet the needs of the prison regime. Prisoners receive the 2 days naloxone training for trainers first, followed by 6 meetings that incorporate the training delivered on days 1 and 4 in the community.

Learning Outcomes from Days 1 and 4

Topics covered from both days

- Drug harms
- Drug groups, effects and their legal status
- A brief history of drugs
- Attitudes and values
- Treatment options
- What is peer education?
- Advantages and Disadvantages of peer education
- Peer led approaches
- Peer information and education
- Aggression-signs and de-escalation
- Brief interventions
- Facilitation skills
- Managing nerves
- Challenging situations

By the end of the 6 follow up sessions participants will be able to:

- Identify and explore values and attitudes around specific drugs
- Recall different drug groups, effects and legal status
- Identify how our values can affect our judgment

- Identify the many reasons why people use drugs
- Recall the principles behind peer education and identify the benefits and drawbacks
- Demonstrate an understanding of the different types of peer-led approaches
- Recall skills in managing awkward or challenging situations and behaviours during training
- Name the main points of facilitating and co-facilitating a group training session
- Plan a naloxone awareness session.

Peer educators are supported by prison staff and health staff to deliver brief interventions in the prison. Staff is then able to ensure that a supply of naloxone is put in a prisoner's personal property for their release.

Tips for a Prison Peer Education Naloxone Programme (delivered by prisoners)

- Promote the training for trainers well in advance
- Provide a named member of staff as the regular contact for all peers
- Provide regular support sessions and progress meetings with peers
- Have all staff involved at the beginning of setting up a programme, i.e. prison staff, health staff etc.
- Incentivise the training for prisoners
- Allow all prisoners to apply for a place on the programme
- Promote brief interventions to deliver training (10-15 minutes)
- Have an internal communication strategy i.e. Prison magazine, radio, TV Channel.
- Recruit long term prisoners, who will be around for a while
- Engage prisoners who may already have a reputation or influence in the prison estate (they are your motivators to other prisoners for the programme to be successful)
- Proper recognition for individuals who are involved in delivering training, should be celebrated and encouraged
- Create naloxone posts for prisoners as their prison job
- Ensure peer educators have a clear structure to provide details of prisoners trained to the staff who will place the naloxone in their belongings

Key Components of a Brief Intervention

When delivering sessions to people likely to witness an overdose, a training session should include the following[1]:

The most common drugs identified in a drug-related death (heroin, methadone, benzodiazepines & alcohol – all CNS depressant drugs) **and the physical effects these drugs have** (slow, shallow, irregular breathing, slow heart rate, feeling less alert, unconsciousness, poor memory, not feeling pain, lower body temp)
The main causes of drug overdose (low tolerance, polydrug use, using too much, using alone, injecting drug use, purity levels)
High risk times (release from prison, leaving rehab or hospital, recent detox, recent relapse, poor physical or mental health, recent life events, cash windfall, longer-term user, festive periods, weekends or holidays)
The signs & symptoms of suspected opiate overdose (pinpoint pupils, breathing problems, skin/lip colour, no response to noise or touch, loss of consciousness)
The common myths (don't inflict pain, give other drugs e.g. stimulants, put in bath/shower, walk person around, leave person on own)
Knows when to call for an ambulance (when person won't wake with shout/ shake, status of person and location)
Knows about the recovery position (person on side, airway open)
Knows about rescue breathing and CPR (30 compressions, 2 breaths – one cycle of BLS)
Knows when and how to administer naloxone (unconscious but breathing – admin when in recovery position then every 2-3mins, unconscious but NOT breathing – admin after one cycle of BLS then after every three cycles of BLS. Dose – 0.4mls into outer thigh muscle via clothing. Assembly of syringe) *this is based on doses of Prenoxad Injection
Knows that naloxone is short acting (the effects of naloxone wear off after 20-30 mins, possible that overdose may return)
Knows the importance of staying with the person (do not let the person use any other drugs if they gain consciousness)

This intervention should be more like a conversation than a training session. The trainer should not just read from the list but engage the person by listening to their experiences or knowledge of overdose and drawing on that information to cover the key points.

[1] note that the main drugs involved and BLS guidance may vary from country to country

Top Ten Tips for Naloxone Programmes

1. **Make 'training' brief**

   - A quick ten minute conversation is enough to provide someone with the basic skills to save a life. Never underestimate the potential outcome of a brief intervention!

2. **Don't tell someone to come back at a later date, just get it done!**

   - Opportunistic conversations while you have the person there in front of you can be the difference between life and death. You don't know if you'll ever see this person again, make sure they're equipped!

3. **Make sure the training and supply happens in the same place**

   - Your programme will be much more successful if you can physically hand over the naloxone after the training. Adding in additional steps may mean many people do not end up with a supply.

4. **Involve peers!**

   - Peers have instant credibility among the target group and hugely enhance the rate of distribution, particularly when they are also enabled to make the supplies.

5. **If someone refuses naloxone from you, you're doing something wrong. Change your message.**

   - The key part of any programme is about relationships. If you can show someone that you genuinely care about whether they (or their friends) live or die, then no-one will refuse the offer of naloxone from you.

6. **Be creative, don't expect people to come to you**

   - Outreach! Go to where the people are, or the services they frequent, and don't rely on an appointment-based programme.

7. **Prioritise the supply to people who use drugs**

   - People who use drugs are most likely to witness an overdose. This should always be where the most effort is placed.

8. **Make sure everyone on opioid agonist treatment has a supply**

   - Everyone you see on OAT should automatically be receiving a supply. You are providing a powerful opiate, you should also provide the antidote. (Yes, treatment is a protective factor but this is about ensuring coverage and makes sense for it to be normalised in this way).

9. Prioritise, normalise and standardise in all drug services

- The biggest risk of death for your client group is accidental and preventable overdose.

10. Always encourage and support people to talk about their experience of using naloxone

- If someone has used naloxone to save a life - congratulate them! This may also have been a traumatic experience and they may need some support. It's also an opportunity for a training refresher and of course a re-supply of naloxone.

Implementation Checklist

Policy makers

- [ ] Legal situation investigated
- [ ] Able to proceed legally
- [ ] Project lead identified
- [ ] Key partners identified
- [ ] Key partners contacted
- [ ] Working group established
- [ ] Funding stream confirmed
- [ ] Suitable product identified
- [ ] Data collection model developed
- [ ] Supply mechanisms confirmed
- [ ] Master trainer identified
- [ ] Training plan devised
- [ ] Peer education model developed
- [ ] Materials produced
- [ ] Communication strategy in place
- [ ] Training for trainers delivered
- [ ] Plan to monitor programme in place

Practitioners

- [ ] Naloxone lead identified
- [ ] Peer involvement lead identified
- [ ] Standard operating procedures in place
- [ ] Paperwork for monitoring in place
- [ ] Materials available
- [ ] Staff training plan in place
- [ ] Staff trained as trainers
- [ ] Prisoners identified for peer education
- [ ] Prisoners trained as peer educators
- [ ] Training rolled out to people likely to witness an overdose

Appendices

Appendix 1: One to One Naloxone Training Checklist

Appendix 2: Session Evaluations

Appendix 3: Naloxone Training for Trainers - Completion Certificate

Appendix 4: Awareness Session Evaluation

Appendix 5: Naloxone Leaflet

Appendix 6: Naloxone Poster

Appendix 7: Use of Naloxone Follow Up Interview/Report

Appendix 1

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One to One Naloxone Training Checklist

Trainee Details

Name	DOB	Address (inc. postcode)	GP Name & Address

The person must demonstrate an understanding of the following:	Trainer Initials
The most common drugs identified in a drug-related death (heroin, methadone, diazepam & alcohol – all CNS depressant drugs) **and the physical effects these drugs have** (slow, shallow, irregular breathing, slow heart rate, feeling less alert, unconsciousness, poor memory, not feeling pain, lower body temp)	
The main causes of drug overdose (low tolerance, polydrug use, using too much, using alone, injecting drug use, purity levels)	
High risk times (release from prison, leaving rehab or hospital, recent detox, recent relapse, poor physical or mental health, recent life events, cash windfall, longer-term user, festive periods, weekends or holidays)	
The signs & symptoms of suspected opiate overdose (pinpoint pupils, breathing problems, skin/lip colour, no response to noise or touch, loss of consciousness)	
The common myths (don't inflict pain, give other drugs e.g. stimulants, put in bath/shower, walk person around, leave person on own)	
Knows when to call 999 (when person won't wake with shout/shake, status of person and location)	
Knows about the recovery position (person on side, airway open)	
Knows about rescue breathing and CPR (30 compressions, 2 breaths – one cycle of BLS)	
Knows when and how to administer naloxone (unconscious but breathing – admin when in recovery position then every 2-3mins, unconscious but NOT breathing – admin after one cycle of BLS then after every three cycles of BLS. Dose – 0.4mls into outer thigh muscle via clothing. Assembly of syringe)	
Knows that naloxone is short acting (the effects of naloxone wear off after 20-30 mins, possible that overdose may return)	
Knows the importance of staying with the person (do not let the person use any other drugs if they gain consciousness)	

The above trainee has demonstrated an understanding and awareness of opiate overdose, the use of naloxone, calling 999, the recovery position and basic life support and is eligible to receive a supply of take home naloxone.

Trainer Name……………………………………………………………………………………………………

Service Name & Address………………………………………………………………………..................................

Trainer Signature……………………………………………………………….. Date………………………………

Appendix 2

Please **print initials** and month birth (Jan-Dec) here e.g. SMJun - _ _/ _ _ _

Pre session evaluation

Have you had any overdose awareness or overdose intervention training before? Yes or No	
If yes, Great!! Where/when was this?	

How confident do you feel about being able to manage an overdose situation? (I.e. knowing exactly what steps to take and when). Please circle one of the following options.	**NOT CONFIDENT**
	UNSURE
	CONFIDENT
	VERY CONFIDENT
Do you feel skilled enough to get involved in an overdose situation? (i.e. the practical skills required to intervene). Please circle one of the following options.	**NOT SKILLED**
	UNSURE
	SKILLED
	VERY SKILLED
What would you say *could be* 3 most important things you can do when confronted with an overdose situation?	
Have you ever witnessed an overdose? Please use one of the following options.	**YES**
	NOT SURE
	NO
What do think the main drugs involved in overdoses or drug related deaths are?	**(A)**
	(B)
	(C)
	(D)
	(E)
***What behaviours* do you think puts a person at most risk of overdose when taking drugs?**	
***When* do you think a person is most at risk of overdosing?**	
In your opinion, and on a scale of 1-10, how serious a problem are drug overdoses in Scotland? **I = Not serious / 10 Very Serious**	

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Overdose prevention, Intervention and Naloxone Test

Question	Answer
What *vital function* stops first when opiate overdoses cause death?	
Name *3 signs* of possible life threatening opiate related overdose	**(1)**
	(2)
	(3)
Name *three factors* that increase the risk of fatal opiate overdose	**(1)**
	(2)
	(3)
What is the major difference in the action of heroin and methadone?	
What is the usual first dose (in ml's) of naloxone, and how would you give it?	
How often/at what intervals would you repeat naloxone administration?	
Does cocaine use increase or decrease heroin OD risks?	
Why is it essential that an ambulance is called, even after naloxone has been given to opiate overdose casualty?	
What three pieces of harm reduction advice could you give to reduce the chances of an opiate overdose:	**(1)**
	(2)
	(3)
First Aid Questions	
What are the 'four steps' involved in getting someone into the recovery position?	**(1)**
	(2)
	(3)
	(4)
Why are rescue breaths so important?	
What is the chest compression to breaths ratio?	**10:1**
	15:5
	30:2

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Post session evaluation

Question	Response
How confident do you feel about being able to manage an overdose situation? Please circle one of the following options.	**NOT CONFIDENT**
	UNSURE
	CONFIDENT
	VERY CONFIDENT
Do you feel skilled enough to get involved in an overdose situation? Please circle one of the following options.	**NOT SKILLED**
	UNSURE
	SKILLED
	VERY SKILLED
What would you say were the 3 most important things you can do when confronted with an overdose situation?	
Have you ever witnessed an overdose? Please use one of the following options.	**YES**
	NOT SURE
	NO
What do think the main drugs involved in overdoses or drug related deaths are?	**(A)**
	(B)
	(C)
	(D)
	(E)
***What behaviours* do you think puts a person at most risk of overdose when taking drugs?**	
***When* do you think a person is most at risk of overdosing?**	

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Overdose Awareness and Naloxone Training For Trainers (T4)

To what extent did the training meet your needs? Please circle one of the following options.	Fully
	Partially
	Not at all

Trainer/facilitator/venue

Please select numbers 1 to 5 for the following questions. 1 being poor and 5 being excellent

The trainers style was	
The trainers subject knowledge was	
The presentations were	
The venue was	
The length/duration of the training was	

Will this training make you more effective in your role or post? If so, how?

How useful was each component of the training?
Please select numbers 1 to 5 for the following questions. 1 being poor and 5 being excellent

Background presentation	
Demonstration of awareness session	
Basic facilitation/presentation/group work skills	
Naloxone Training	
Emergency Basic Life support	

Please let us have any additional comments or thoughts about the training day/s

Finally, if you could assist us with completing an online evaluation at a later date please provide with a suitable email address (please print) and phone number.

Email:		Phone:	

SDF
Scottish Drugs
Forum

Informing
Supporting
Representing
Leading

Certificate Of Completion

This certificate is awarded to

Name

To acknowledge that the above named person has completed

OVERDOSE PREVENTION, INTERVENTION & NALOXONE TRAINING FOR TRAINERS

Granted on Completion Date

Trainer Name

National Naloxone Training & Support Officer

Appendix 4

Informing
Supporting
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Course Title: Overdose Prevention, Intervention and Naloxone Awareness Session

Course Trainer: **Date:** **Venue:**

To what extent did this awareness session meet your needs?

Fully	
Partially	
Not at all	

Trainer/venue **1 being poor & 5 being excellent** *Please tick*;

	1	2	3	4	5
The trainer style was					
The trainer subject knowledge was					
The presentations were					
The venue was					
The length/duration of the session was					

Will today's session make you more effective in your role or post? If so, how?

How useful was each component?

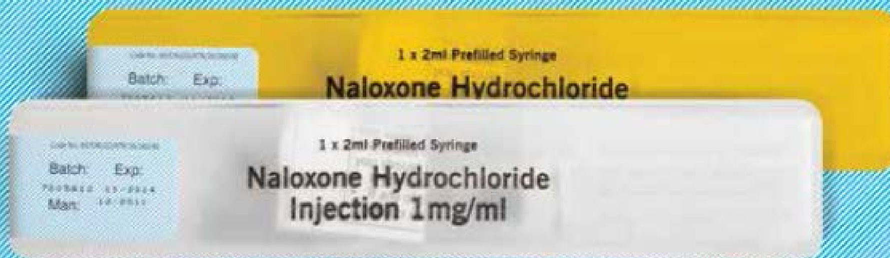
	Not	A little	Fairly	Very
Background presentation				
Overdose prevention				
Naloxone awareness				
Emergency Basic Life Support				

Please let us have any additional comments or thoughts about the training day

Appendix 5

NALOXONE CAN BE A LIFESAVER

1

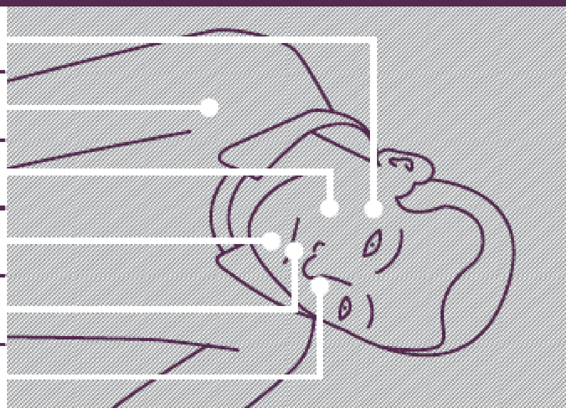


Naloxone is a drug which can temporarily reverse the effects of opioid (heroin/methadone) overdose. In an overdose state, **it can be a lifesaver**

SAVE SOME NALOXONE

WHAT TO DO IF SOMEONE HAS OVERDOSED

SIGNS & SYMPTOMS



1/ Try to wake the person up/get a response by **shaking their shoulders and shouting** "open your eyes" or "wake up".

2/ If they don't wake/respond, make sure you **open their airway**, by gently tilting their head back and opening their mouth. Look, listen and feel for signs of breathing for 10 seconds.

3/ If you see/hear/feel breathing during this 10 seconds put them in the recovery position. If you have **naloxone** available, assemble the kit, then inject 0.4mls by pushing the plunger to the first black line marked on the barrel into the upper, outer thigh (at a 90° angle to the surface of the skin). Inject straight through clothes. Return the kit to its box, set it aside (in case it's needed later). **Phone 999, ask for an ambulance.**

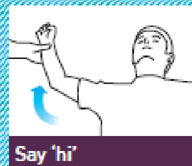
4/ If they are not breathing, **phone 999** and ask for an ambulance right away. Explain where the person is, and that they are unconscious and not breathing.

5/ Start chest compressions. With the heel of the hand in the centre of the chest, give **30 compressions** followed by **2 rescue breaths**. This is called 1 cycle of CPR.

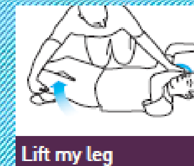
6/ If **naloxone** is available – assemble the kit, then inject 0.4mls by pushing the plunger to the first black line marked on the barrel, into the upper, outer thigh muscle. Inject straight through clothing. Return the kit to its box, set it aside (in case it's needed later).

7/ Continue with chest compressions /rescue breaths and give 3 more cycles. Inject **naloxone** again. Continue giving 3 cycles of CPR and **naloxone**.

RECOVERY POSITION


Say 'hi'

Support my face


Lift my leg

Roll me over

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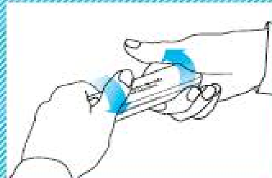
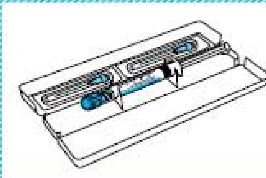
HOW TO SET UP A NALOXONE KIT

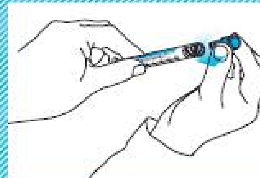
At time of writing, naloxone kits in Scotland will have red tamper evident tape on each end of the pack. This must be removed prior to the following steps.



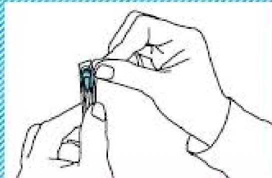
1/ Twist the outer plastic box to break the tamper evident seals and open.



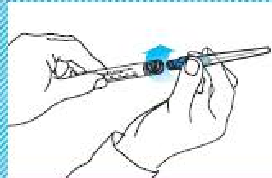
2/ The box contains 1 syringe of naloxone and two needles.



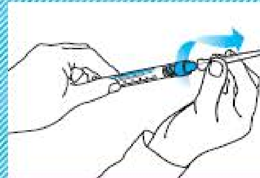
3/ Unscrew the clear plastic top from the syringe.



4/ Peel back the backing paper from the needle packet and remove the needle in its protective sheath.

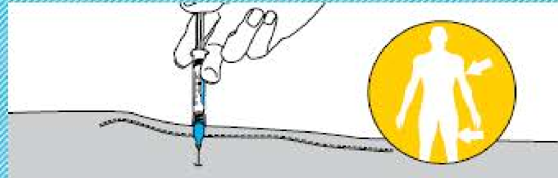


5/ With the needle still in its sheath, screw the blue fitting on to the syringe.



6/ Gently twist the needle sheath and remove it from the syringe.

7/ To inject someone who has overdosed, hold the syringe like a pen.



8/ Insert the needle into the patient's outer thigh or upper arm, through clothing if necessary, and inject first dose (0.4ml) at a 90° angle. Withdraw the needle and syringe after each dose.

THE FACTS

DEPRESSANTS /

HEROIN / DIAZEPAM / ALCOHOL / METHADONE

Mixing downers like heroin, benzos (e.g. diazepam) and alcohol can kill you, especially if you take other medications like methadone. Some of these downer drugs can stay in your system for many hours, sometimes days, so it's very easy to think you're not mixing them.

LOWERED TOLERANCE

You're at greater risk of overdosing if your tolerance is lowered. It may be lowered when:

- **Just out of prison, rehab or hospital.**
- **You've been using less.**

You may be at risk of dying by overdose if you use combinations of the drugs mentioned above – even small amounts of each drug mixed together can kill you.

HOW TO HELP

THE CASUALTY MIGHT NOT HAVE MUCH TIME

Make sure that you are calm and where you are is not too noisy.

Dial 999 and ask for an ambulance. Tell the call handler the **location** (where the casualty is and any landmarks that might make it easier for the crew to find them). Tell the call handler the status of the casualty, for example if they are:

- **UNCONSCIOUS**: They don't stir when you shout/shake them
- **UNCONSCIOUS AND NOT BREATHING**: They are 'lifeless' - won't wake up and you can't see, hear or feel breathing for at least 10 seconds

You may be asked what happened. If you don't know or are not sure, tell the call handler that.

If you know what the person has taken, it may be helpful to tell the call handler. If you prefer not to say, **don't let that stop you from phoning an ambulance.**

OVER 80% OF CASUALTIES ARE ALREADY DEAD BY THE TIME AN AMBULANCE ARRIVES.
THAT IS WHY IT IS IMPORTANT TO CALL THE AMBULANCE EARLY.

THE ROLE OF THE POLICE

Most of the time in Scotland, the police will be notified about and **may** attend the scene. **Remember**, in some areas, the police may be the first to arrive at the scene and will provide vital first-aid assistance. If the casualty is still alive **it is their duty** to do all they can to help preserve life.

This is because the police, like the ambulance service, **see saving lives as their priority.**

It is not a priority for the police to seek the prosecution of any individual suffering an overdose or any person helping them.

MAKE THE CALL
SAVE A LIFE

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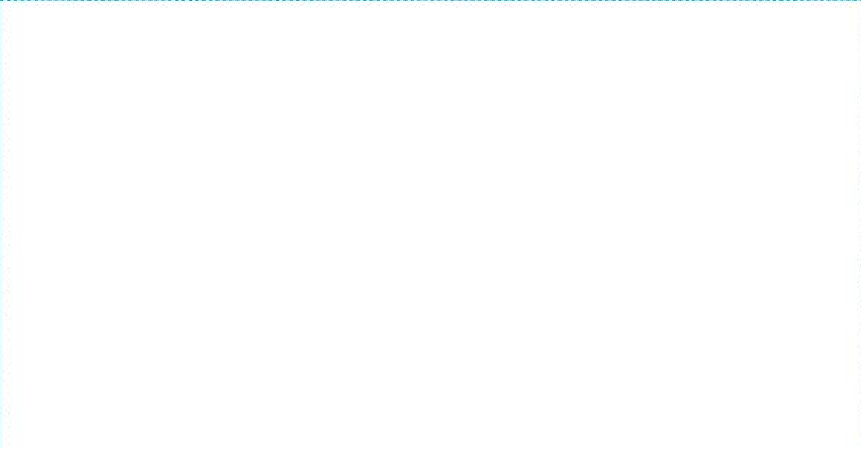
FOR FURTHER INFORMATION ABOUT HOW YOU CAN ACCESS FREE NALOXONE TRAINING AND YOUR OWN SUPPLY CONTACT:



Appendix 6

NALOXONE SAVED MY LIFE

"You hear about it all the time, but you never think it'll be you. I just remember coming round... My boyfriend standing there with the naloxone syringe in his hand. He was crying, he thought I was dead. He saved my life. It's made me think about keeping myself safe from now on."

SAVE SOME NALOXONE

NALOXONE CAN TEMPORARILY REVERSE THE EFFECTS OF OPIOID OVERDOSE

For more information on being supplied with and trained to use naloxone, ask at your local drug service or needle exchange.

WWW.NALOXONE.ORG.UK / WWW.SDF.ORG.UK

Appendix 7

SDF
Scottish Drugs Forum

Informing
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Follow Up Interview/Report

The following form should be used as a brief guide (prompt for further details)

Before proceeding, establish whether the overdose was:
FATAL OR NON FATAL? (Delete as appropriate)

Details of person providing information	
Name	
Date of birth	
Area of residence	

Date & place (include location/area) of where person overdosed	

Details of person who overdosed -					
Male/Female				Age	
Receiving opioid replacement therapy?	**YES**	**NO**	**DON'T KNOW**	Relationship to person providing information	**FRIEND** **FAMILY MEMBER** **OTHER (please specify)**
Substances involved (If known)					
Had the person injected?	**YES**	**NO**	**DON'T KNOW**		

Were you present when the person overdosed?	**Yes**	**No**
If yes, how long did it take for them (from point of using) to overdose?		
What were the signs/symptoms of overdose?		
How many other people were present (Apart from you and the person who overdosed)?		

Sequence of Events -		
Naloxone administered?	**YES**	**NO**
	How many doses?	
	If No, please provide reason	
Ambulance phoned?	**YES**	**NO**
	If No, please provide reason	
What information did you give the emergency call handler?		
Did the emergency call handler talk through the naloxone process?	**YES**	**NO**
	Any other comments?	
Recovery position?	**YES**	**NO**
	If No, please provide reason	
CPR Performed?	**YES**	**NO**
	If No, please provide reason	
Did you wait with the person who overdosed until help arrived?	**YES**	**NO**
	If No, please provide reason	
How long was it before the ambulance arrived?		

Did the person who overdosed attend hospital	**YES**	**NO**	**DON'T KNOW**
	If No, please provide reason		
How long did you stay with the person who overdosed after the paramedics left?			

Did the Police attend?	**YES**	**NO**
	Details of any action taken	

Any additional information (including how person feels following incident/confidence etc)

Refresher training Provided?	**Yes**	**No**

Signed ……………………………(staff member) **Date** ………………………

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My First 48hrs Out - Comprehensive Approaches to Pre and Post Prison Release Interventions for Drug Users in the Criminal Justice System

Project Director - Prof. Dr. Heino Stöver

Project Manager - Arailym Erkebaeva

www.harmreduction.eu/projects/my1st48h

www.frankfurt-university.de

www.isff.info