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Moves toward wider availability of Naloxone

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Despite the "heroin shortage", about one Australian a day still dies from an overdose, most involving heroin. For about 20 years there have been calls to make naloxone (Narcan®) more available to people who use opioids, their friends, family members and other potential overdose witnesses to help prevent overdose deaths (Lenton et al 2009). However, getting people into opioid substitution treatment remains our mainstay overdose prevention strategy.

Naloxone

Naloxone is the emergency medicine that temporarily reverses the effects of heroin and other opiate drugs. In Australia, as elsewhere, naloxone is widely used in hospital emergency departments and most ambulance services as a key response to opiate overdose. Over 40 years use in this setting has shown it to be safe, reliable and effective. However, naloxone is currently only available on prescription in Australia (Lenton et al 2009).

Naloxone has a very specific action in reversing the effects of opioid intoxication. It does not produce any intoxication itself and has no effect on people who don't have opioids in their system.

What is happening overseas?

Naloxone distribution and training programs currently operate in the UK, USA, Canada, Germany, Georgia, Russia, Spain, Norway, Afghanistan, China, Kazakhstan, Tajikistan and Vietnam. It has been available across the counter in Italy since 1995 (Eurasian Harm Reduction Network 2010). The experience from overseas shows that naloxone is a very safe and

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Healthy people. Strong communities.

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Reforming opioid treatment in Australia

Guest editorial by Associate Professor Nicholas Lintzeris, Director, Drug and Alcohol Services, SESLHD
c/o The Langton Centre, New South Wales

In the late 20th century, Australia was at the forefront internationally in its response to the public health crises posed by injecting heroin use. We can no longer lay claim to be at the cutting edge in how we treat opioid dependence. It is time that we review our approach.

A key element of Australia's response was the rapid expansion of opioid substitution treatment, based around methadone. Methadone is a very safe and effective medication when delivered by skilled clinicians as part of a treatment plan for opioid dependent clients. However, methadone has an unusual pharmacology that means that methadone can be unsafe if delivered by unskilled clinicians, or if taken by individuals for whom it was not intended (e.g. children, people seeking intoxication). Appropriate safeguards were necessary to enable the safe expansion of methadone treatment, including state and national clinical guidelines, mandatory training and accreditation for doctors and pharmacists, "permit" systems linking patients to individual doctors to prevent methadone "doctor shopping", and supervised dosing with restricted take-away policies. This framework was also applied to buprenorphine on its introduction a decade ago.

Safeguards have become obstacles

Many of the safeguards essential in expanding methadone treatment have now become obstacles to the treatment of opioid dependence.

The need for daily supervision for the majority of buprenorphine-treated patients is unnecessary. It is much safer than methadone following accidental overdose (particularly for children; Boyer et al. 2009). Australian research (Bell et al. 2007) and international experience (e.g. USA) indicates that buprenorphine-naloxone can be safely and effectively delivered without daily supervised dosing. The overemphasis upon supervision increases the cost to the client (often cited as a major barrier), reduces treatment capacity in many services, and is a major inconvenience to both clients and staff.

Current restrictions regarding who can deliver opioid substitution treatment limits the number of treatment providers, exhausting a treatment sector that is struggling to keep up with treatment demand. There is an impending crisis in some states where very large numbers of clients are treated by a handful of doctors nearing retirement. Mandatory training is essential to prescribe methadone safely, but less onerous training should be available to prescribe buprenorphine.

Our current opioid substitution treatment system may be contributing to the increase in pharmaceutical opioid use among people who use drugs in Australia, given:

- our inability to meet demand for treatment
- the cost and inconvenience of supervised dosing
- the absence of alternative opioid medications for those not attracted to, or responding to, methadone or buprenorphine.

Does it need to stay this way?

We need more flexible approaches to how we regulate and deliver treatment. We can make treatment

more accessible by reducing our emphasis upon supervision of buprenorphine-naloxone, and reducing the regulatory barriers to health providers using this medication. It is also time that we reconsider alternatives to "oral" methadone and buprenorphine, including injectable opioid treatment (Strang et al. 2010) and other abuse deterrent opioids (e.g. containing morphine or oxycodone).

We must recognise the needs of different client groups, and the different tiers of expertise in our workforce (specialists, generalists). We must develop better regulatory and prescription monitoring systems that enable us to tailor safeguards such as supervised dosing to those patients and doctors who require it, and not rely on the "one size fits all approach" currently dominating our thinking. If we fail to do so, opioid substitution treatment will further ossify into a marginalised treatment sector driven by regulations rather than patient circumstances and clinical judgement.

If all you have is a hammer—
everything looks like a nail.
We can do better.

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Street based heroin use in Vietnamese communities

Peter Higgs, Viral Hepatitis Epidemiology and Prevention Program, The Kirby Institute, University of New South Wales, New South Wales

Uncovering and understanding the dynamics of street drug scenes requires methodological approaches and questions that go beyond simply determining the amount of behavioural risk-taking that occurs. Since the mid 1990s, I have been particularly interested in exploring why and in which contexts this risk-taking occurs with ethnic Vietnamese who use heroin.

In my interviews and observational fieldwork, it is clear that perceptions of risk are not necessarily constituted in the same way for participants, as they are for public health workers or researchers. My research has uncovered a number of local harm reduction and self-protection issues that require further consideration. Designing interventions that account for these may be possible but they will need to accommodate the specific contexts in which these locally adapted harm reduction responses have developed.

Interventions specifically targeting ethnic Vietnamese people who use heroin will also need to accommodate current approaches from law enforcement, which appear to be very focussed on "moving the problem on". The cycle of incarceration and time in the community requires creative approaches from the justice system. High rates of risk-taking in correctional facilities mean that sentencing alternatives to prison are necessary. If these are to work with ethnic Vietnamese people their creators will need to develop programs that integrate people into more mainstream activities that generate income. The entrenched experiences of marginalisation faced by many of these ethnic Vietnamese people will make it difficult to develop such programs.

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In terms of developing and targeting interventions at the local level, there is a need to examine injection "risk behaviours" as a process rather than as risk episodes. While there is a great deal of knowledge that sharing of needles and syringes leads to the transmission of blood borne viruses, other risks are less understood. For example, the mixing of heroin and diphenhydramine as a cocktail, requires using different injecting equipment, and so may be considered a risk process rather than a risk episode.

Risk associated with overdose for people who use heroin occasionally has been noted previously by researchers in this field. Recent hepatitis C peer education with ethnic Vietnamese in Footscray indicates that there may be a specific role that "older brothers" can play in terms of educating others about overdose. There is some evidence to suggest that because they have stopped regular heroin use, they may have higher credibility with younger people who use heroin.

Peer education activities and programs may be one way of preventing overdose though the stigma attached to illicit drug use means that these will not automatically be the solution.

In summary, there are many issues to consider when exploring risk with street based heroin use especially among those of Vietnamese ethnicity. The development of solutions for reducing the risks associated with heroin use must also consider that narrowly focussed strategies will not necessarily be effective in targeting all people at risk. The stigma and shame associated with heroin use will mean that new initiates to heroin use may not congregate in the same places as people who have been using heroin long term. This will mean active and assertive outreach that keeps abreast of the changing nature of street drug markets and of the drugs of choice of participants in these markets.

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Heroin and other opioids in Aboriginal people who inject drugs in Victoria

Peter Waples-Crowe, Team Leader, Public Health & Research Unit,
Victorian Aboriginal Community Controlled Health Organisation, Victoria

When I was asked to write this paper I started by contacting different national organisations to try to get a picture of the patterns of heroin use in Australia. At the same time a new research paper was released from the Australian National Council on Drugs (ANCD). This research paper titled *Injecting drug use and associated harms among Aboriginal Australians* (Kratzmann 2011), brings together all the evidence around injecting drug use in Aboriginal Australia to give a clearer picture of what is happening across the country.

Trying to find reliable data on the use of drugs by Aboriginal people is difficult. The organisations that collect this information are often not prepared to release it as the numbers are small and data can often lead to the further stigmatisation of Aboriginal communities and people. In the ANCD report, the data suggest that heroin use in Australia peaked in 1999 and dramatically dropped by 2001, while injecting drug use has continued and seems to have shifted to other drugs such as amphetamines.

This shift in drug use is echoed in some recent data we collected here in Victoria. The Sexual and Reproductive Health Unit of the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) has been concerned about the high rates of hepatitis C and HIV contracted through injecting drug use in the Aboriginal community (National Centre in HIV Epidemiology and Clinical Research). In 2009/10 we conducted a few projects under the name of Yiaga ba Wadamba (which means "to find and renew" in the local Wurundjeri language). As part of these projects we spoke with 69 Aboriginal people who inject drugs about their injecting practices, sexual health, and use of health services from across Victoria (VACCHO & Anex 2010).

The average age of the participants in the project was 34 years and the average length of injecting drug use was 13.8 years ranging from 8 months to 30 years. These were not new injectors, but gave us a snap shot of drug use among an older cohort of Aboriginal people who use drugs. Of the 69 Aboriginal people who injected drugs, 34 were from Melbourne and 35 were from regional Victoria. Forty-one were asked about their primary drug of choice: 20 reported heroin, 17 reported amphetamines, three reported other opioids (morphine etc.) and one reported cocaine. The people who reported other opioids were from regional areas, citing a shortage or poor quality of heroin in their region.

Despite the fact that this was a small sample and probably biased towards Aboriginal people who access Aboriginal health organisations the data provide an opportunity to look at drug use patterns among Aboriginal people who inject drugs in Victoria in an area where accurate national data are scarce or not often published.

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The prescription drug "epidemic" in the US: What is the response?

Suzanne Nielsen, NIDA Invest CTN Fellow, UCLA Integrated Substance Abuse Programs, Los Angeles, California; Senior Research Fellow, Turning Point Alcohol and Drug Centre; and Adjunct Senior Lecturer, Eastern Health Clinical School, Monash University, Victoria

There has been acute awareness of problems relating to prescription opioids in the United States (US) for at least the past decade. By 2002, the number of deaths from prescription opioids exceeded that reported from heroin or cocaine.[1] Ten years later, this number is still increasing. According to recent statistics from the White House Office of National Drug Control Policy (ONDCP) one person dies from a drug overdose every 19 minutes in the US, and more people die from prescription drugs than gunshot wounds.[2] Death rates from prescription drugs in some geographic locations such as Florida are four times the number of deaths from illicit drugs, with a 265 per cent increase in oxycodone deaths from 2003 to 2009.[3]

Responding to the problem

The Centers for Disease Control and Prevention has released a plan to respond to what is being described as a "prescription drug abuse epidemic".[4] The plan includes the following four key elements:

- Expansion of Prescription Drug Monitoring Programs (PDMP). Currently, 43 states have plans for PDMPs, but only 35 are operational. Studies of these programs have identified that they are effective.
- Programs to safely and environmentally responsibly destroy unwanted medications.
- Education to increase awareness of the risks associated with prescription medication and other issues such as safe storage. One element of education will include the opioid risk evaluation and mitigation strategy (REMS).
- Law enforcement activities targeted at "doctor shoppers" and "pill mills".

Details of the REMS plan are still in development. Under discussion are some key elements such as mandatory prescriber training, including:

- learning how to recognise evidence of, and potential for, opioid misuse, abuse and dependence
- medication guides and risk assessment plans for certain medications.

A modest expansion of treatment has been identified in the plan (a goal of a 10 per cent expansion in treatment over 36 months); though there is recognition that only a small fraction of those who need treatment currently have access to it.

Pharmaceutical misuse in Australia

Recent recognition of pharmaceuticals as a problem in Australia has led to the development of a National Pharmaceutical Drug Misuse Strategy, with a discussion paper released in March as part of a national consultation.[5] Some ideas developed in the US may translate well to Australia, though there are also some differences in healthcare and the treatment systems that might warrant consideration.

In the US there are many uninsured people who have limited access to healthcare. The differences in drug treatment in the US include:

- methadone is available free for those who qualify, but in relatively restrictive clinic settings
- buprenorphine is much less restricted and can be prescribed by any licensed doctor (often with weekly or monthly unsupervised medication supplied) but at a considerable expense to program users without medical insurance.

In comparison, treatment in Australia is usually relatively low cost for either methadone or buprenorphine irrespective of the person's health insurance status. Both prescriber and medication costs are subsidised. While these treatments are more expensive than treatments for other chronic conditions in Australia, it appears that at least buprenorphine treatment is more affordable than in the US.

It will be important to see if the proposed measures for reducing prescription drug–related problems are effective in the US, and to consider which of these measures may be appropriate and effective in an Australian setting. Although prescription drug problems have long been identified in the US the response has been slow while the problem has dramatically escalated. The earlier development of a National Strategy to respond to Pharmaceutical drug problems in Australia[5], along with approaches such as harm reduction being an important component in Australia's National Drug Strategy[6] will hopefully contribute to averting a similar epidemic in Australia.

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The Pharmacotherapy, Advocacy, Mediation and Support service (PAMS) based at Harm Reduction Victoria

Sarah Lord, The PAMS Service, Organisational Services Team Leader,
Harm Reduction Victoria (formerly VIVAIDS Inc.), Victoria

The Pharmacotherapy, Advocacy, Mediation and Support (PAMS) service is a state-wide telephone service for Victorian pharmacotherapy consumers and their direct service providers. The service deals with consumer complaints and concerns regarding the Victorian pharmacotherapy program. It provides advocacy, support, information, mediation and referral. It operates via a 1800 number (free call, state-wide) and is open from Monday to Friday, between the hours of 10am and 6pm.

PAMS calls and consumer issues

The majority of calls to PAMS come from Victorian consumers who have a problem with their program that they cannot sort out on their own. In dealing with any call, the main aim is to ensure that the consumer can pick up their next dose of pharmacotherapy with relative ease and that treatment continuity is maintained if that is the consumer's goal.

Calls to PAMS can involve any of the following:

- expired prescriptions and the primary prescriber is unavailable
- problems with take-away doses
- concerns relating to dose administration
- uncertainties about prescribing and dispensing guidelines and consumer rights
- dispensing fee debt, payment problems and differing payment arrangements
- program termination
- access to alternative services, including issues of discrimination relating to service access, (particularly in rural/regional Victoria)
- how to make a complaint and possible outcomes of complaining.

Rural/regional issues for consumers

Most of the issues faced by consumers are exacerbated in rural and regional areas where there are:

- greater distances to travel to access services
- heightened issues of dependence-related stigma and discrimination
- fewer drug and welfare support services (including counselling, education and referral)
- consumer concerns relating to confidentiality breaches by service providers and spreading of harmful gossip by other consumers.

PAMS service delivery

As an independent, third party, PAMS is frequently able to negotiate resolutions between consumers and service providers. We aim to assist in the formulation of amicable, "win-win" solutions for all parties. Sometimes, just providing an opportunity for either party to vent their concerns with somebody removed from the situation can be of assistance. Similar to other Harm Reduction Victoria programs, PAMS is a peer-based service for pharmacotherapy consumers.

PAMS is not funded to provide financial assistance for consumers with problems relating to dispensing fee debt. However, a significant proportion of pharmacotherapy consumers who contact the service are calling in relation to this very issue. We have spent many years building relationships with welfare services that do have emergency relief and brokerage throughout the state in the hope that we will be able to access a limited amount of "one-off" financial assistance for individual clients. In other cases, PAMS often negotiates a repayment agreement between the consumer and service provider that is then drawn up and faxed through to the pharmacy. We also provide ongoing support to both parties for the duration of any repayment contract we have negotiated.

Given the time pressures on pharmacists and prescribers involved in pharmacotherapy programs, PAMS can assist by providing a wide range of verbal and written information and resource material to individual consumers and service providers.

Referrals

Both consumers and service providers can self refer to PAMS. Referrals also come from DirectLine, alcohol and other drug services, Centrelink, mental health services, welfare organisations, significant others and through word of mouth. We encourage pharmacies and prescribers to inform consumers of the existence of PAMS and to ensure our promotional material is always available.

Further Information

If anybody would like any further information about the PAMS Service at Harm Reduction Victoria, please contact Sarah Lord on 1800 443 844 or (03) 9329 1500.

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The primary healthcare model—a foundation for evidence based alcohol and other drug practice

Dr Ingrid van Beek AM, Director, Kirketon Road Centre, New South Wales

I have been privileged to have been centrally involved in the development of what is arguably Australia's most comprehensive primary healthcare model—the Kirketon Road Centre (KRC)—since it first commenced operating in 1987.

Kirketon Road Centre was established in response to a recommendation of the NSW Select Committee of the Legislative Assembly Upon Prostitution that '… the NSW Government fund a multi-purpose health centre in [Sydney's] Kings Cross area'. In keeping with the Committee's stipulation that the centre be fully accessible and acceptable, KRC adopted the primary healthcare philosophy as first articulated by the World Health Organization in 1978, thereby committing to providing healthcare in an acceptable, accessible, affordable and equitable way.

The aim of the service is to prevent and treat HIV/AIDS and other transmissible infections among "at risk" young people, sex workers and people who inject drugs. The focus of KRC over these past 24 years has increasingly shifted towards the development of interventions to prevent harms associated with illicit drug use—particularly heroin and other opioid-related morbidity and mortality. This includes injecting-related injury and disease leading to impaired venous access with implications for transmission of blood borne infections and opioid overdose.

This shift also occurred as it became clear that reductions in both sexual and injecting risk behaviour could only be sustained when people's drug use and life situations were not "out of control". It was realised that access to alcohol and other drug (AOD) assessment linked to opioid dependence pharmacotherapies were the key to gaining the lifestyle stability needed to encourage self-care, which underpins better health and social outcomes for all.

Kirketon Road Centre's integrated "one-stop shop" model includes a suite of medical, nursing, counselling, and social welfare services as well as a "low threshold" (low entry barriers) methadone access, needle syringe and outreach programs. As well as ensuring a holistic approach to the often complex health needs of these populations, this broader health service model has also reduced potential service stigmatisation associated with being explicitly identified as an "STD", "AIDS" or "drug clinic".

The early development and integration of a research capacity in this primary healthcare setting has enabled contact with some of the most hard-to-reach populations. The collaboration of clinicians, researchers and clients so close to the clinical coalface has allowed emerging AOD issues to be promptly identified, assessed and documented. This has lead to a systematic evidence-based approach to the development of appropriate public health responses.

Examples of this translation of research evidence into clinical practice are KRC's methadone access program, which was first piloted in 1993; and its Prevention of the Transition to Injecting project (2006–2010), which arose from its national surveillance role as a sentinel site for hepatitis C incidence among people who inject drugs.

The Centre is currently involved in a project monitoring the occurrence of injecting-related injury and disease among people who inject drugs, and evaluating the demonstration of injecting technique provided by clinicians at the time of venepuncture for blood borne infections. It is expected that once evaluated this intervention will become part of standard care at KRC. Later this year, KRC also hopes to trial the feasibility of prescribing naloxone to people who inject drugs and their peers to prevent fatal opioid overdose.

The results of research into the effectiveness of the various interventions used at KRC have been disseminated in more than 30 peer-reviewed publications and more than 20 editorials, commentaries, book chapters, monographs and other published reports over the years. In this way the broader public health research field has been informed by the clinical coalface, and public health services have evolved from the evidence-base.

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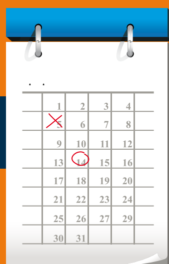
Calendar



September

26–28 September 2011

Public Health Association of Australia 41st Annual Conference, Brisbane, Queensland

www.phaa.net.au/41stPHAAAnnualConference.php

27 September 2011

Heroin and Other Opioids Seminar, Melbourne, Victoria

http://www.druginfo.adf.org.au/druginfo-seminars/seminar-heroin-and-other-opioids

October

3–5 October 2011

Contemporary Drug Problems Conference: Beyond the Buzzword—Problematising 'Drugs', Prato, Italy

http://ndri.curtin.edu.au/events/cdp2011

18–20 October 2011

Oceania Tobacco Control Conference, Brisbane, Queensland

www.oceaniatc2011.org

23–27 October 2011

9th Asia Oceania Congress of Geriatrics and Gerontology, Melbourne, Victoria

www.ageing2011.com

November

9–11 November 2011

The Australian & New Zealand Adolescent Health Conference: Youth Health 2011, Sydney, New South Wales

www.youthhealth2011.com.au

11–13 November 2011

General Practitioner Conference and Exhibition (GPCE), Melbourne, Victoria

www.gpce.com.au

13–16 November 2011

Australasian Professional Society on Alcohol and other Drugs 2011 Conference, Hobart, Tasmania

www.apsadconference.com.au

December

1 December 2011

World AIDS Day

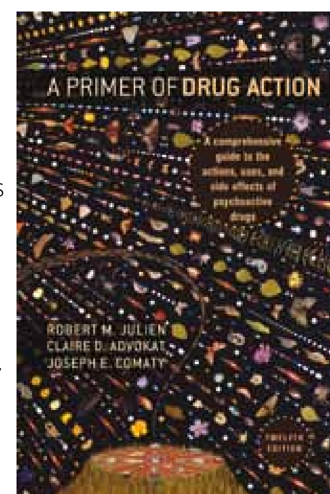
www.worldaidscampaign.org

Review

Ian Comben, Information Officer, *DrugInfo*, Australian Drug Foundation

A primer of drug action 12th edition
A comprehensive guide to the actions, uses and side effects of psychoactive drugs

Julien R, Advokat C & Comaty J. 2011
New York: Worth Publishing



This book has been described as the definitive guide to the effects of psychoactive drugs on the brain and behaviour. It is a concise and readable guide to the actions, uses and side effects of psychoactive drugs.

The book has been fully updated, and provides readers with a look at every drug and medication that either positively or adversely affects brain function.

This edition includes information on:

- antidepressant drugs
- drugs used to treat bipolar disorder
- sedative-hypnotic and anxiolytic medications
- non-narcotic anti-inflammatory analgesics
- herbal medicines and natural treatments for psychological disorders
- cannabinoid agonists and antagonists
- child and adolescent psychopharmacology
- geriatric psychopharmacology.

The book covers general principles for each class of drug and contains specific information about each drug in that class.

A comprehensive chapter on opioid analgesics includes information on the history, terminology and classification of opioids, as well as numerous illustrations to explain the various chemical structures of a range of opioid analgesics.

A primer of drug action is an authoritative and comprehensive text and is suitable for those with little background in biology. It is also an indispensable source of information for anyone interested in the actions of particular drugs and the consequences of substance misuse.

This book is available to purchase through the Australian Drug Foundation bookshop at **www.bookshop.adf.org.au**

Review

Anna Gifford, Resource Centre Manager, Australian Drug Foundation

Polygon: the many sides to the Australian opioid pharmacotherapy maintenance system

Ritter A & Chalmers J 2009 ANCD Research Paper no. 18, Canberra: Australian National Council on Drugs
DrugInfo no. HK25 RIT

www.ancd.org.au/images/PDF/Researchpapers/rp18_polygon.pdf?phpMyAdmin=rGQ2XkOOsKjMp24r2sFwuVc5ibb

Modelling pharmacotherapy maintenance in Australia: exploring affordability, availability, accessibility and quality using system dynamics

Chalmers J, Ritter A, Heffernan M
& McDonnell G 2009 ANCD Research Paper no. 19, Canberra: Australian National Council on Drugs
DrugInfo no. HK25 CHA

www.ancd.org.au/images/PDF/Researchpapers/rp19_modelling.pdf?phpMyAdmin=rGQ2XkOOsKjMp24r2sFwuVc5ibb

Pharmacotherapy maintenance treatment for opioid dependence has been offered in Australia for opioid dependence since 1969. The Australian National Council on Drugs (ANCD) commissioned these complementary reports to evaluate the effectiveness and issues surrounding this treatment approach in Australia.

The first report, *Polygon*, sets the scene and presents a qualitative review of pharmacotherapy maintenance treatment issues such as affordability, accessibility, consumer involvement, child protection, and rural and remote issues.

Seven issues are identified as the most significant facing the Australian opioid pharmacotherapy maintenance system:

- the overall goals of the program
- service delivery models
- affordability for clients
- accessibility of the system
- medication non-adherence and diversion
- unsupervised dosing
- the role of counselling.

The second report, *Modelling pharmacotherapy maintenance in Australia*, presents a system dynamics model of the service system that explores some of the policy implications in addressing the issues outlined in *Polygon*.

While it is often used in health research, system dynamics modelling is a relatively new technique in drug policy. This model focuses on the themes of affordability, availability, accessibility and treatment quality, and demonstrates its potential in understanding the impact of changing the system to address these issues.

Pharmacotherapy maintenance treatment for opioid dependence is an important strategy to support people with opioid dependence. These two reports clearly present the key issues, and some potential ways to address them.

Web reviews

Karen Gough, Web Support Officer, *DrugInfo*, Australian Drug Foundation

Beacon

http://beacon.anu.edu.au

Beacon is an initiative of the Centre for Mental Health Research. It is a portal to online and mobile resources for mental and physical disorders. Links are provided to websites and mobile applications relating to a wide range of disorders. Each linked site is also reviewed and rated by experts, to assist people searching for information in this area.

This useful site is clearly written, easy to navigate and covers a broad range of topics including alcohol dependence, bipolar disorder, depression, eating distress (body image, anorexia, bulimia), stress, tinnitus, weight and obesity, phobias, post-traumatic stress disorder, resilience, social anxiety, generalised anxiety disorder, obsessive compulsive disorder, pain and panic disorder.

...CONTINUED FROM PAGE 1

effective intervention when used by trained peers. As of 2010, there were 155 programs operating in 16 states in the USA with 53 339 naloxone kits dispensed and 10 194 overdose reversals reported (Wheeler 2011).

Internationally, overdose management and naloxone administration training has typically involved:

- the causes and prevention of overdose
- assessment of an overdose, necessity of calling an ambulance
- overdose management including life support
- naloxone and its administration
- post naloxone monitoring and support
- communication with ambulance and police services.

Evidence shows such training increases knowledge and skills resulting in safe and effective administration of the drug. Although there has not been a randomised controlled trial of the impact of the intervention on opiate overdose deaths at a population level, observational studies show reductions in overdose deaths where naloxone programs have been implemented (Lenton 2011).

Naloxone programs in Australia

While we wait for naloxone to be rescheduled in Australia to make it available over the counter, steps are being taken to commence prescription naloxone programs under existing legislation. As long as the medication is being administered to the person to whom it is prescribed, no laws are broken. Based on the international experience at least three Australian jurisdictions have begun planning such schemes. Most developed is that of the Expanding Naloxone Availability in the ACT (ENAACT) committee which is developing a program to recruit 200 people who use opioids and potential overdose witnesses to be trained in overdose prevention and management including administration of naloxone. Under the plan, the person who uses opioids and a peer or family member will receive the approved training from a peer educator. The person who uses opioids will then be assessed by a doctor and if appropriate will be prescribed and supplied with naloxone. The program will be evaluated and, along with developments in other states, should contribute to the more widespread availability of naloxone in Australia (Lenton 2011).

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