EXPANDING USE OF TAKE-HOME NALOXONE TO PREVENT DEATHS FROM OPIOID OVERDOSE

RECOMMENDATION

That members:

- **NOTE** recent developments regarding the distribution and use of take-home naloxone (THN).
- **APPROVE** funding for a CSFM project proposal to assist in widening the distribution and use of take-home naloxone in Australia.

PURPOSE OF THE PAPER

To provide an overview of recent developments relating to opioid overdose deaths in Australia and opportunities to prevent these deaths through wider distribution and use of take-home naloxone (THN) programs, and describe the next steps required.

SUMMARY OF ISSUES FOR DISCUSSION

Opioid related deaths constitute the bulk of the illicit drug related deaths in Australia. The projected estimates for accidental opioid deaths for 2012 and 2013 were 596 and 632 respectively\(^1\). Reducing these deaths is a policy priority under the draft National Drug Strategy.

Take-home naloxone (THN) programs involve training potential overdose witnesses (e.g. people who use opioids, their friends and families) in overdose response including naloxone administration and then distributing naloxone to help reverse overdose.

Emerging evidence from THN programs in New South Wales, Western Australia, Victoria and South Australia and the ACT indicate that these programs are effective, low risk and contribute to saving peoples’ lives. There is no evidence that wider availability of naloxone leads to riskier or more widespread drug use. The Australian programs to date however have tended to operate on a relative small scale (typically under 200 participants).

A two year project is proposed to support scaling up THN programs to widen distribution and use of naloxone and thereby reduce opioid overdose morbidity and mortality in Australia.

The project will be conducted under expert guidance from a reference group made up of leaders from Australian THN programs and relevant personnel from

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\(^{1}\) Roxburgh, A. and Burns, L. (2015)
pharmaceutical services from within State/Territory and Commonwealth Health Departments.

The project aims to promote in:

- **ambulance services** greater consistency in the telephone scripting utilised to encourage administration of THN by bystanders in an emergency and routine provision by officers of brief interventions and THN after attending opioid overdose call outs
- **Emergency Departments** routine provision of a brief intervention and THN to people presenting following opioid overdose
- **specialist drug treatment and support services operating opioid maintenance treatment programs, withdrawal services and drug rehabilitation programs** routine provision of opioid overdose education and THN for people with a history of opioid use
- **primary health care centres, Aboriginal Medical Services and general practice** for routine provision of brief interventions and THN for people with a history of opioid use; and
- **full time detention facilities/ custodial settings** routine provision of brief interventions THN for those leaving with a history of opioid use.
- **Police and fire brigade first responders** knowledge of naloxone and exploration of potential routine provision for resuscitation.

The project will consolidate relevant research and educational materials to support those working in these settings to widen distribution and use and promote consistent recording of related data.

**BACKGROUND**

According to the *National Pharmaceutical Drug Misuse Framework for Action (2012-2015)*, Australia has experienced a substantial increase in opioid supply in recent years (Dobbin, 2011) with a range of associated harms including pharmaceutical drug-related emergency department presentations and fatal and non-fatal overdoses.
Figure 1. shows an increase in the supply of methadone, morphine, codeine and in particular oxycodone between 1991 and 2010. Between 31 December 1991 and 31 December 2010 the Australian population increased by 29% [Australian Bureau of Statistics, (1992) & Australian Bureau of Statistics (2011)]. During this time there was an increase of 228% by weight in the pharmaceutical opioid base supply to Australia (data provided by Dobbin, 2011).

The increase in supply of most of these medications is not necessarily problematic of itself. Unfortunately, the increase in supply has been accompanied by an increase in harms. The increase in harms is following trends seen in other developed countries such as the United States (Centers for Disease Control and Prevention, 2010) and Canada (Dhalla, et al. 2009).
In 1998-99 pharmaceutical opioids accounted for 33% of opioid poisonings, but by 2007-08, this had grown to 80% (see Figure 2.). It is clear that the cause of poisoning has shifted from heroin to pharmaceutical opioids.

In 2014, the World Health Organization (WHO) produced guidelines recommending that countries expand naloxone access to people likely to witness an opioid overdose in their community in order to reduce the global burden of death from overdose. (World Health Organisation (2014). Community Management of Opioid Overdose. Geneva: Author)

People who inject drugs in Australia continue to experience elevated mortality (1% per annum, 17 times greater than the age-matched community), most often due to opioid overdose. Opioid Maintenance Treatment (e.g. methadone) reduces but does not eliminate this risk. In Australia there were around 48,000 people on Opioid Maintenance Treatment in June 2014. Among Opioid Maintenance Treatment clients in NSW 1985-2005 the estimated opioid overdose death rate was 3.8 per 1000 person years and the average years per life lost was 45.8 years.

Naloxone has a dual listing currently on the Australian Pharmaceutical Benefits Schedule. It is available as both a Schedule 3 (pharmacist only – over the counter) and as a Schedule 4 (requiring prescription) medication for treatment of opioid overdose.

However, there significant issues with THN naloxone that require further work and/or consideration. These are issues with:

1. The available preparation of naloxone itself.
   - There is only one naloxone product suitable for THN sourced through one manufacturer, leading to problems with security of supply.
   - Costs to consumers for over-the-counter provision are high.
   - Naloxone is currently listed (exclusive of dispensing fee) as a 400 microgram minijet®. Based on findings from the existing Australian programs, 30-50% of reversals required 2 or more minijets® of naloxone to be administered. An 800 microgram minijet may be a more suitable dose
   - Available preparations are suited for intramuscular injection. Alternative intranasal devices are now approved by the US FDA and these easily-administered preparations should be actively explored for the Australian context.

2. Program reach
   - Current programs only allow for dispensing through pharmacies or directly from prescribers, opportunities for programs that allow for workers other than doctors and pharmacists to supply naloxone (e.g needle and syringe program workers) such as those in the United States to be explored
   - Overseas experience shows that a broader range of frontline workers than paramedics can be trained in naloxone administration. This includes police and fire brigade.
3. Legal protections
   Current Australian legislation varies in terms of the extent to which THN participants are protected as “Good Samaritans” who administer naloxone in life-saving situations. This legislation needs harmonisation, and one mechanism to achieve this may be to explore specific legislation related to THN.

Results of consultations with jurisdictions / implications for other ministerial councils – N/A.


Providing advice to Ministers on the most effective responses to prevent and respond to overdose is included the IGCD’s Statement of Priorities for preventing and reducing illicit drug related harm.

Regulation impact statement – N/A

Cost-shared budget implications – attached

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ATTACHMENTS: CSFM proposal.