Overdose Prevention and Naloxone Distribution: Models and Best Practices
Maya Doe-Simkins
Baltimore, MD
September 2, 2015

US Naloxone Distribution Landscape:

Strategies for maximizing opioid safety

Modify prescribing practice
• Staged treatment (FDA relabeling)
• Medication reconciliation
• Risk factor screens
• Good faith

Reduce morbidity & mortality
• Layperson naloxone

Reduce diversion
• PDMP
• Pharmacy reviews
• Take-back programs
• Pain contracts
• Abuse deterents

Manage substance use
• Opioid agonist treatment
• Good Samaritan laws
• Comorbid SUD treatment
• Supervised injection facility

Expand non-medication pain management
• PT/OT
• Behavioral therapy
• Acupuncture
• Massage

Slide courtesy of Phillip Coffin & Emily Behar
UNINTENDED CONSEQUENCES WERE NEVER UNANTICIPATED CONSEQUENCES

Evaluations of overdose education and naloxone distribution (OEND) to laypersons

Feasibility

- Piper et al. Subst Use Misuse 2008: 43; 858-70.
- Walley et al. JSAT 2013; 44:241-7. (Methadone and detox programs)

Increased knowledge and skills


No increase in use, increase in drug treatment


Reduction in overdose in communities


Cost-effective


Plaintiff focus on people who use drugs

- Rowe et al. Addiction 2015; 1360-0443

Naloxone is effective...

- Walley, 2013

No coverage

1-100 ppl

100+ ppl

Wiley. 2013
Evidence challenges & ethical considerations

- RCTs
- Difficult to power
- Difficult measures
- Network effect
- Relatively weak design, but results all in same direction

BEST PRACTICES
People who use drugs are key

<table>
<thead>
<tr>
<th>Enrollments</th>
<th>Overdose rescues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-drug Users: 31%</td>
<td>Non-drug Users: 13%</td>
</tr>
<tr>
<td>Drug Users: 69%</td>
<td>Drug Users: 87%</td>
</tr>
</tbody>
</table>

Walley, 2013

The more the better

- Dose response effect - Walley, 2013
- 9-20 x past year avg OD fatalities - Bird, 2014

Finite resources, must prioritize?

- People who use drugs
- Other incidental bystanders
- Summoned responders
  - Experiencing incarceration (Binswanger, 2013)
  - Entering & exiting treatment for OUD (Strang, 2003)
  - Experiencing homelessness (Baggett, 2012)
  - Living with HIV/AIDS (Green, 2012)
MODELS, ADAPTATIONS & CONSIDERATIONS

Enrollment locations: 2008-2014 (first half)

Data from people with location reported: Users: 17,494  Non-Users: 9,275
Currently > 28,000 enrollees and >3300 overdose rescues documented

MDPH Program data

Challenges for community programs

- Naloxone cost is increasing, funding is minimal
- Missing people who don’t identify as drug users, but have high risk
- Missing people who may periodically misuse opioids=no tolerance

Opportunities for prescription naloxone

- Co-prescribe naloxone with opioids for pain
- Co-prescribe with methadone/ buprenorphine for addiction
- Insurance should fund
- Increase patient, provider & pharmacist awareness
- Universalize overdose risk

Non Users (family, friends, staff)
Models for Prescribing Naloxone

**Setting: clinic with insured patients**

1. Staff provide OEND on-site
   - Pharmacies alerted to prescribing plans
   - May need to have atomizers on-site for intranasal formulation
   - Consider providing informational brochure

2. Outside staff provide OEND on-site
   - OD prevention integrated
   - Interagency cooperation
   - Low burden on staff

3. OE provided onsite, naloxone received off-site
   - OD prevention integrated
   - Interagency cooperation
   - Increased patient burden to get naloxone

4. Outside staff recruit near MMT or detox
   - Confidential access to OD prevention

**Models for OAT and detox**

<table>
<thead>
<tr>
<th>Model</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff provide OEND on-site</td>
<td>• Good access to OEND</td>
<td>• Patients may not disclose risk</td>
</tr>
<tr>
<td>2. Outside staff provide OEND on-site</td>
<td>• OD prevention integrated</td>
<td>• Community OEND program needed</td>
</tr>
<tr>
<td>3. OE provided onsite, naloxone received off-site</td>
<td>• OD prevention integrated</td>
<td>• Increased patient burden to get naloxone</td>
</tr>
</tbody>
</table>
| 4. Outside staff recruit near MMT or detox | • Confidential access to OD prevention | • OD prevention not re-enforced in treatment
| | | • Not all patients reached |

Slide courtesy: Alex Walley & Prescribe To Prevent

**SUD Treatment**

- Screening
- Intake Assessment
- Trauma screening
- Orientation Group/individual counseling
- Positive drug screen
- Discharge
- When there is an overdose event
- International Overdose Awareness Day

**Models for OAT and detox**

<table>
<thead>
<tr>
<th>Model</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff provide OEND on-site</td>
<td>• Good access to OEND</td>
<td>• Patients may not disclose risk</td>
</tr>
<tr>
<td>2. Outside staff provide OEND on-site</td>
<td>• OD prevention integrated</td>
<td>• Community OEND program needed</td>
</tr>
<tr>
<td>3. OE provided onsite, naloxone received off-site</td>
<td>• OD prevention integrated</td>
<td>• Increased patient burden to get naloxone</td>
</tr>
</tbody>
</table>
| 4. Outside staff recruit near MMT or detox | • Confidential access to OD prevention | • OD prevention not re-enforced in treatment
| | | • Not all patients reached |
SUD treatment and social services providers

- “Ethical dilemmas”
- Legal basis of the project
- Demonstrate-person/mannequin

- Interactive!
- Experiences with overdose
- Trauma experiences-referrals?
- Supervision?

**Messaging re: strong/adulterated heroin**

1 IN 5 OVERDOSE DEATHS HAPPEN IN PUBLIC BATHROOMS

**CHECK YOUR RESTROOMS YOUR ACTIONS COULD HELP SAVE A LIFE**

**KNOW WHAT TO LOOK FOR**
- Unconscious
- Slow breathing
- Lack of breathing
- Blue lips/fingers

**KNOW WHAT TO DO**
- Call 911 immediately
- Perform mouth-to-mouth breathing
- Administer Narcan

Rural settings

- No harm reduction programs
- Drug user social networks- difficult
- 911 calls different?
- Police/fire- impt role
- Loved ones- at homes? Internet?
People released from incarceration

- Primary cause of death for ppl who have experienced incarceration
- Early pilots relied on naloxone referral upon release, pick-up rate was dismal
- Preferred model: Naloxone distributed at point of release

Binswanger, 2007

Evidence demonstrate that notwithstanding ex-prisoners’ very high risk of overdose death soon after release, their altruism and concern for others is such that when naloxone is administered, the recipient is twice as likely (36:17) to be some-one other than the ex-prisoner. (Bird, 2014)

Outreach

- Explore partnerships
- Go to locations where PWUD might be
- Respect peoples’ space
- Respect peoples’ existing knowledge & time
- Work with frequent refills
Sessions with PWUD

- VALIDATE group member’s experiences
- Ask what they know about each topic
- Clarify “old school” methods (“myth busting”)
  - “If you tried to help you did the right thing.”
- Respect confidentiality
- Discuss options, plans
- Monitor group domination
- Be prepared for a range of emotions
- Refer when appropriate

Considerations for families & loved ones

- Referrals
- People behind the data
- Fear, anger, sorrow, regret, shame
- Overdose-SUD context
- Advocacy & stories
- People who have lost someone are different than people who have loved ones currently struggling
- Living @ home
Conclusions

• “What is the goal?” affects intervention design
• Evidence says people who use drugs
• The more naloxone in a community, the better
• Wildly adaptable
• Challenge stigma

MAYA DOE-SIMKINS
mdoesimkins@gmail.com

Acknowledgements:
Dan Bigg & CRA
Alex Walley & MDPH
Photographers & their subjects