European Monitoring Centre
for Drugs and Drug Addiction

PROGRAMME

Take home naloxone to reduce fatalities: scaling up a participatory intervention across Europe

14 October 2014

EMCDDA, Lisbon

Take home naloxone to reduce fatalities: scaling up a participatory intervention across Europe

Venue
EMCDDA/EMSA Conference Centre
Praça Europa, Cais do Sodré
Lisbon

Tuesday, 14 October 2014	
10.00	Registration of participants (Reception of the EMCDDA, Praça Europa 1)
10.30	**Poster session** — Foyer of the Conference Centre
13.00	**Session 1: Understanding opioid overdose deaths and rationale for take home naloxone** Opening and introduction — Paul Griffiths, Scientific Director, EMCDDA Chair: John Strang, National Addiction Centre (NAC), London and Dagmar Hedrich, EMCDDA • Reducing the burden of disease attributable to opioid dependence — Wayne Hall, Centre for Youth Substance Abuse Research University of Queensland (AU) and NAC London • Drug-related deaths in Europe — Isabelle Giraudon, EMCDDA • Overview of studies on the provision of take-home naloxone — Marica Ferri, EMCDDA • Update on N-ALIVE: a randomized trial about naloxone distribution on release from prison — John Strang, NAC, London
15.00	Coffee/Tea break
15.30	**Session 2: Take-home naloxone interventions: regulations, experiences, achievements and challenges** Chair: Dagmar Hedrich, EMCDDA and Marica Ferri, EMCDDA • Distribution and use of naloxone: legal issues — Brendan Hughes, EMCDDA • A 3-year model project of take home naloxone in Germany — Kerstin Dettmer, Fixpunkt e.V., Berlin • Involving the network of drug abuse care centers of Catalonia in an overdose prevention programme — Xavier Major Roca, Department of Health, Catalonia • Naloxone in Scotland: a national approach — Kirsten Horsburgh, National Naloxone Coordinator, Scottish Drugs Forum • The Danish naloxone scheme — Henrik Saelan,Consultant for The Danish Health and Medicines Authority, Copenhagen • Take home naloxone in Estonia — Katri Abel-Ollo, National Institute for Health Development and Head of Estonian Drug Monitoring Centre • Nasal naloxone, as take-home provision for users and relatives in Norway: first experiences — Thomas Clausen, Norwegian Centre for Addiction Research
17.00	**Moderated discussion: 'Scaling up naloxone'** Moderator: Roland Simon, Head of unit: Consequences, responses and best practices, EMCDDA Panel: Heino Stöver, Michel Mallaret and Gill Bradbury
18.00	**Poster session** — Foyer of the Conference Centre
	Refreshments

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Session 1 Summary

Session 1: Understanding opioid overdose deaths and rationale for take home naloxone

Date/Time: Tuesday, 14 October, 13.00 – 15.00h

Type: Plenary Session

Chairpersons: John Strang, National Addiction Centre, London (UK) and Dagmar Hedrich (EMCDDA)

Paul Griffiths (Scientific Director at the EMCDDA) opened the meeting followed by John Strang (UK) who welcomed the opportunity the meeting provided to address such an important topic. He highlighted the fact that implementation of take home naloxone to reduce fatalities is an intervention that has been very slow to develop in Europe adding that this is very different from other types of drug treatment. Dagmar Hedrich (EMCDDA) outlined the objective of the session, which was to give an overview of take home naloxone as part of a comprehensive response to reduce opioid overdose deaths. She advised the meeting that it would be audio recorded and filmed and that presentations will be made available on the website after the meeting, with the agreement of presenters.

Wayne Hall (Centre for Youth Substance Abuse Research University of Queensland, Australia) gave a presentation on reducing the burden of disease attributable to opioid dependence, making use of literature reviews and methods of estimating years of life lived with disability (YLD), years of life lost (YLL) and disability-adjusted life years (DALYS). He also presented estimated contributions of opioids, stimulants and cannabis to the global burden of disease (BoD) in 2010. He highlighted the main contributors to the opioid burden of disease and suggested how it can be reduced. Finally, he highlighted specific risk factors for opioid overdose and pointed to some methods to reduce these such as: opioid substitution treatment, peer education and distribution of naloxone to opioid users, especially in post-prison, detoxification and rehabilitation settings. Further information at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961530-5/fulltext?_eventId=login

Isabelle Giraudon (EMCDDA) gave an overview of drug-related deaths in Europe based on use of definitions and protocols developed with experts for the Drug Related Death

(DRD) key indicator to monitor DRD in 30 countries. She presented numbers, rates, trends with graphs and maps stressing that opioids are involved in most overdoses reported in EU. There were at least 6700 overdose deaths in Europe in 2013; most were premature and avoidable deaths which might have been avoided with naloxone. She added a note of caution regarding the provisional nature of the recent data presented as it is still under a validation process with National Focal Points and national experts. Comparisons between countries also need caution due to differences in methods and reporting. Further information at www.emcdda.europa.eu/themes/key-indicators/drd.

Marica Ferri (EMCDDA) gave an overview of studies on the provision of take home naloxone. Drug overdose is one of the major causes of death among young people in Europe, with recent data showing that it accounts for approximately 3.5 % of all deaths in adult males under 40 years of age. Opioids are the primary cause of lethal overdoses. Naloxone is an effective antidote to revert opioid intoxication (including synthetic opioids). As these overdoses often occur in the presence of peers or family members, programs that enable them to provide first aid and administer naloxone can save lives. The overview of studies shows that the communities implementing these programs effectively reduce the overdose mortality. Further information at http://www.emcdda.europa.eu/best-practice

John Strang (UK) provided an update on N-ALIVE: a randomized trial about naloxone distribution on release from prison. The N-ALIVE randomised trial started in 2012, to investigate whether heroin overdose deaths post-prison-release can be prevented by provision of take home naloxone. Most heroin overdoses are due to opiate-induced respiratory depression and are usually witnessed by drug users or family members who can intervene. The period following release from prison is a time of extraordinarily high mortality. One in 200 prisoners with a previous history of heroin injecting released from prison die of a heroin overdose within the first four weeks. Take-home naloxone is slowly being implemented in some community schemes but more scientific evidence is required. Further information at http://www.kcl.ac.uk/iop/depts/addictions/research/drugs/N-ALIVE.aspx

N-ALIVE trial trigger videos on Youtube:
https://www.youtube.com/watch?v=Xbnx5Q3vZek
https://www.youtube.com/watch?v=w_qAHdjfFUE
https://www.youtube.com/watch?v=S4kQ3iVUFMs

Minutes: Deborah Olszewski

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Session 2 Summary

Session 2: Take home naloxone interventions: regulations, experiences, achievements and challenges

Date/Time: Tuesday, 14 October, 15.30 – 17.00h

Type: Plenary Session

Chairpersons: Dagmar Hedrich and Marica Ferri (EMCDDA)

Dagmar Hedrich (EMCDDA) opened the session with the main objective, which was to improve knowledge about implementation of take home naloxone interventions (THN) interventions by sharing experiences of innovative practices and trials in Europe. She advised the meeting that – with the agreement of presenters –power-points and audio/ video recordings would be published on the EMCDDA website, to make the topic and current work accessible to a wider audience.

Brendan Hughes (EMCDDA) outlined some legal issues concerning the distribution and use of naloxone, which may be limited by issues of: availability (licences and other controls); prescribing and use (limits on the people permitted to use it); and legal penalties that may affect those possessing or using naloxone (including concerns about "facilitating/encouraging illegal drug use" and liability in the event of a death of a drug user after an unsuccessful application of naloxone). Preliminary exploration suggests that legal issues are driven less by the substance (its pharmacological properties) than its route of administration, which is commonly by injection.

Kerstin Dettmer (Fixpunkt e.V., Berlin, Germany) presented findings from a project of take home naloxone. In 1998, the NGO "Fixpunkt" combined first aid training and naloxone distribution for opiate users in Berlin and from January 1999 opiate users attending a healthcare project (operating from a mobile van or ambulance) were offered training in emergency overdose resuscitation and provided with naloxone. Provision included two 400 µg ampoules of naloxone, needles, syringes, an emergency handbook, as well as information about naloxone. After 3 years, 525 opiate users had received training in resuscitation and 264 were provided with supplies of take home naloxone. 105 cases of Naloxone usage in total were documented. Evaluation showed that responsible use of Naloxone is possible. It also provides motivation to take part in first aid training and helps to build trust. "Fixpunkt" has continued to implement first aid training combined with take home naloxone however lack of funds make it possible on a very low level. However training courses for professional workers have become established.

Xavier Major Roca (Programme on Substance Abuse of the Department of Health of the Autonomous Government of Catalonia, Spain) presented an overdose prevention programme involving a network of drug abuse care centres in Catalonia. Overdose prevention is built on: easy access to methadone programmes, which covers approximately 8.000 individuals; safe consumption rooms, which supervise over 100.000 consumptions per year. Education and naloxone distribution takes place through care centres but especially 27 harm reduction facilities.

The programme is based on protocols, which have been adopted by most harm reduction facilities. However, less than half of the drug treatment centres, therapeutic communities and detoxification units participate in the programme. To increase coverage and reach the most high risk drug users shorter and more flexible training interventions and inclusion of peers in training should be considered. Involving prisons is another important next step.

Kirsten Horsburgh (National Naloxone Coordinator, Scottish Drugs Forum, UK) presented the national approach to naloxone in Scotland against a background of some of the highest and increasing drug-related deaths rates in Europe. She highlighted some common circumstances surrounding drug-related deaths (such as. at home, several hours between overdose and death, recent abstinence and witnesses present). She described the developments in Scotland leading to the national program being launched in 2010 adding details about the product used, who delivers it and how the programme is monitored. The current target is to reach 25% of problem/high risk drug users in Scotland by March 2015. They intend to expand the programme to support delivery in prison, to engage GPs and further engage police and for this a flexible approach that provides a brief (10-15 minute) intervention is key.

Henrik Saelan (Consultant for the Danish Health and Medicines Authority and National DRD Expert for Denmark) described the positive experience of a pilot scheme in Copenhagen that led to a state financed project with naloxone in 4 Danish municipalities with open drug scenes, beginning in March 2013 and ending in 2015. The main objectives were to: reduce opioid related overdose deaths; reduce the adverse health effects of non-fatal OD´s; and to develop sustainable systems to prevent overdoses in the participating municipalities. To date, 100 individuals have been trained as trainers, 121 drug users have been trained, 121 Naloxone kits (a nasal spray in the first instance, which can be followed by an injection if required) have been distributed and 7 instances of naloxone use recorded. However, as there was already a significant drop in DRDs before the project evaluation of the scheme will be limited.

Katri Abel-Ollo (Head of the National Focal Point, Estonia) spoke about take home naloxone in Estonia. The National Institute for Health Development launched the take home naloxone pilot program in 2013 to respond to the high drug-related death rate in Estonia. The objective of the program is to teach the opioid users and their relatives to recognize overdose, administer naloxone and provide the first aid until emergency services arrive. The program works in the cooperation with targeted healthcare units and local harm reduction services, operating in two large regions. Inclusion criteria are: age ≥ 16 years, an opioid user, a relative named by an opioid user or a provider of methadone treatment or needle exchange service. The take home kit includes a 2 ml naloxone injection (Prenoxad) with two needles and information material. During the period of September 2013 - June 2014, 554 people were trained, 552 naloxone kits were distributed and 72 repeat kits were dispensed. Most of the participants were injecting drug users.

Thomas Clausen (Norwegian Centre for Addiction Research SERAF, University of Oslo, Norway) spoke about a recent project to provide nasal take-home naloxone for users and relatives. Despite the provision of opioid maintenance treatment currently covering approximately 60% of the target population, the number of drug overdoses remains high. The Norwegian Minister of Health launched a national overdose prevention strategy in April 2014, which includes the introduction of take home naloxone nasal spray (for users, relatives and staff in low-threshold facilities). Nasal administration was chosen for its easy and rapid administration and to reduce risks associated with contaminated needles. The project is launched in Oslo and Bergen as a trail for two years. Take home kits are distributed after a short training session of approximately 15 minutes with a key message to always call an ambulance. Following a positive evaluation at the end of the trail it may be implemented nationally. Having government support is considered an important success factor but the cost of the kits and the need for reliable, low-cost, user-friendly nasal devices are obstacles. Importantly, staff members have noted that drug users feel empowered from being given the responsibility for ‘saving someone’s life’.

To end the satellite meeting a short film was shown to provide a historical view of Naloxone (1997) and this was followed by a panel discussion. Heino Stöver (Fachhochschule Frankfurt, Germany) highlighted the problem of persuading drug and prison services that are abstinent

oriented to discuss naloxone. There is a tendency to avoid addressing issues about the risk of relapse with clients who are completing their treatment or time in prison or rehabilitation and it is these people who are most at risk. Gill Bradbury (UK) gave some real life examples based on her experience of work in the prison service and elsewhere. Michel Mallaret (France) spoke about the need for more innovative thinking in France about how to prevent drug overdoses.

Minutes: Deborah Olszewski

Further information

Naloxone take home programmes will be the topic of a publication in the EMCDDA *Insights* series to come out in 2015.

Additional web-links to video material about preventing overdose deaths and pre-provision of naloxone.

Brief video-clip from Lifeline, 2010: http://www.fead.org.uk/video294/John-Strang-on-the-death-rate-for-heroin-injectors-and-our-failure-to-reduce-some-of-the-harm.html

Film by the UK Red Cross about peer-led overdose training: http://www.omni-productions.co.uk/our-work/british-red-cross/