EDITORIAL

Now is the time to take steps to allow peer access to naloxone for heroin overdose in Australia

Heroin overdose deaths are preventable. Overdose prevention in Australia has largely rested on opioid substitution treatment supplemented with outreach services and education for injecting drug users (IDUs) about overdose risks and responses. We believe now is the time to make naloxone hydrochloride (Narcan®) available to Australian IDUs to help prevent overdose deaths.

At the end of 2000 heroin availability and harm in Australia rapidly declined [1]. Despite this, overdoses involving heroin or diverted pharmaceutical opioids continue to account for most illicit drug-related deaths in this country. In 2005, the last year reliable data were available [2], at least one citizen died from accidental opioid overdose each day, most related to the injection of heroin [3]. Heroin is still the drug of choice among the majority of Australian IDUs [2]. To date, there is no evidence that levels of heroin overdoses have increased to levels seen in the 1990s. However, transient geographical clusters of overdoses are evident in ambulance transport data (e.g. [4]). This pattern is consistent with the high number of low weight ‘scatter importations’ of heroin (through mail and air passenger traffic) that increasingly characterise heroin importations detected at the Australian border since 2004 [5].

Since the mid 1990s there have been calls to make naloxone available to heroin users, their peers and family members to prevent overdose deaths [6,7]. Lenton and Hargreaves reviewed the literature in 2000 and concluded that peer naloxone had real promise as part of a comprehensive overdose–response, but that an Australian trial was needed before naloxone was made more widely available in this country [8,9]. The dramatic decline in heroin overdose that accompanied the heroin ‘shortage’ [1,10] meant that the proposed trial did not proceed.

However, accumulating international evidence since 2000 shows that the provision of naloxone, with appropriate training, to IDU peers, family members and outreach workers can lead to successful heroin overdose reversals with few, if any, adverse effects (e.g. [11–13]). Indeed, many thousands of doses of naloxone have been distributed for this purpose. In the US alone, over a thousand cases of overdose reversal by peers using naloxone have been documented [11]. By December 2008 there were 52 peer–naloxone distribution programs operating across 17 US States [13]. None of the major concerns about the intervention (such as unsafe administration of naloxone, problems with re-intoxication where longer acting opioids have been used, or more risky drug use if heroin were to be seen as less dangerous) have eventuated and naloxone has been shown to be a remarkably safe intervention when administered by trained IDU peers [11,13–15]. The effectiveness of the intervention probably reflects the fact that training heroin users and their peers in naloxone administration has only been implemented as part of a comprehensive approach to overdose management (e.g. [12,16–18]).

A major concern relating to peer naloxone has been the legal ramifications of administering drugs to a third party [8,19]. In response to this concern, specific ‘Good Samaritan’ legislation has been enacted in some jurisdictions (e.g. the UK and some states of the USA) in order to indemnify against prosecution those third parties who in good faith administer a life-saving drug. Prescription and scheduling issues also present as possible systemic barriers to implementing these programs. In California, New York, New Mexico and Connecticut naloxone can be legally prescribed to third-party lay people [13]. In other jurisdictions (e.g. Italy) naloxone is available over-the-counter, thereby eliminating the necessity of a prescription, and there have been no adverse consequences reported [13]. Another concern has been raised around the potential for blood-borne virus transmission as naloxone has traditionally been administered by injection [20]. However, intranasal administration of the drug has been successfully trialled with paramedics, thereby decreasing any risk of blood-borne virus transmission through needle stick injury [21]. Intranasal naloxone kits are distributed by health authorities in New Mexico and Massachusetts [13] and there are now case reports of 74 successful overdose reversals by peers using intranasal naloxone in Boston [16]. These developments show that the barriers to wider naloxone distribution are certainly surmountable [19].
international randomised controlled trial of naloxone distribution to post-release prisoners will shortly commence in the UK [22].

In spite of the evidence, no formal programs for naloxone distribution for peer administration currently exist in this country. However, Australian IDUs are ready for such a scheme. A recent survey of IDUs in Melbourne found nine in 10 thought peer naloxone was a ‘good’ or ‘very good’ idea and were willing to participate in associated training programs [23]. Support from key bodies, such as the Australian Medical Association, the Public Health Association and the Australasian Professional Society on Alcohol and other Drugs would be welcome to facilitate policy and program development. Overseas training programs could be readily adapted for the Australian context.

We believe that existing international evidence clearly suggests that making naloxone more widely available in Australia will prevent many overdose fatalities. Given the existing evidence, a trial in this country is now unnecessary and Australian governments should take steps to increase access to naloxone. Wider distribution of naloxone as part of overdose prevention training should begin with known high-risk groups, namely those most at risk of overdose because of reduced tolerance: prisoners about to be released and people who exit abstinence oriented drug treatment programs. Careful monitoring and evaluation would be a prerequisite. Monitoring and follow-up protocols can be adapted from those used in the USA (e.g. [12,16,24]) and the UK (e.g. [15]).

While rates of heroin availability and harm currently remain modest in this country, Australians are still dying from opioid overdose and we need to begin the protracted process of removing scheduling and legislative barriers to more widespread availability of naloxone. At a minimum, Australian states should begin by promptly enacting Good Samaritan legislation to protect lay people using naloxone in an emergency situation. Beyond this, rescheduling naloxone from S4 to S3 or S2 to make it available across the counter would greatly facilitate access to the drug. The patent on naloxone has expired [13], so there is no financial motive for a pharmaceutical company to seek rescheduling. However, it could be rescheduled here under provisions that allow State health authorities, professional associations or the national Drugs and Poisons Schedule Committee itself to initiate the process. We urge the alcohol and other drug and sector and the relevant authorities to take action now to remove legislative barriers to more widespread availability of naloxone, whether or not heroin availability in Australia increases in the near future.

Acknowledgement

The argument we make in this Editorial was summarised in a brief letter to the Editor to the Medical Journal of Australia which has recently been published [25].

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References


