Strategies to Address Barriers to & Concerns With Implementing Overdose Prevention Including Naloxone Distribution/Prescription (OPND) in Opiate Treatment Programs

Logistical

Barriers and Concerns	Questions to Consider & Options
What model to use?	What kind of support do you have and from where does it come? In general, a standing order model needs the most widespread support and can traverse systems/organizations, a prescription model is more restrictive though effective on an organizational level (like an OTP), and a distribution model is a more covert approach in the absence of support.
Who is the prescriber(s)?	Is the medical director supportive? Does the OTP have a collaborative relationship with other physicians? Is the medical director of the local EMS willing– they already have experience with naloxone. Is the local public health department supportive? Will they aid in a prescriber search?
Where to get the prescriptions filled?	Retail pharmacies do not stock naloxone or the nasal adapter (for IN). Options include working with individual pharmacies to stock it– usually independent pharmacies and those who use Cardinal (or McKesson) as their distributor are the least complicated. Hospital pharmacies are another option– they likely already have naloxone, just not for retail use. The quickest solution may be to order naloxone and hand it out yourself. IM naloxone (.4mg/mL) is available from Hospira, IN (2mg/2mL) is available from IMS/Amphastar, and the nasal adaptor (MAD) is available from Wolfe-Tory.
Common staff concerns– liability, safety, workload, training	Liability concerns may be addressed by having a clear workplace overdose response policy. Safety concerns can stem from reports of violence w/ naloxone, which is exceedingly rare in bystander administered naloxone and may be due to reasons other than naloxone in EMS and ED settings. Workload is a very important concern– consider combining or switching out some HIV prevention groups for OD prevention groups? Do a survey of clients to discover which orientation session ranks the lowest and replace that one with OD prevention? Identify a client(s) who knows about OD prevention and can train other clients– provide a regular space for this? Staff training is among the first steps to take– it increases buy-in, helps normalize overdose conversations, defines common terms, and inspires creativity
TOO MANY HURDLES– what about overdose prevention and management training without naloxone?	This is a good first step. Certainly, it is an important step in gaining staff support and buy-in. Ultimately, a comprehensive overdose prevention strategy includes both the education *and* the tools to be able to respond to an OD. The naloxone itself is a tangible and useful tool to which clients and loved ones respond very positively.

Philosophical

Barrier and Concerns	Response
Methadone associated overdose does not really affect OTP clients.	Clients have both experienced and witnessed many overdoses. Clients have lost loved ones to overdose. Some clients are polysubstance users– both licit and illicit. Opioid overdose *absolutely* affects OTP clients.
Will having naloxone increase people's risky substance use behavior?	People who received OD prevention & management training with naloxone actually reported *less* drug use and *more* treatment access than prior. (11, 12)
This is not appropriate in a treatment and recovery setting.	Anecdotal evidence describes benefits for both clients and staff in substance abuse treatment settings. Clients report feeling a shift from their treatment compliance being valued to their actual life and existence being valued. Clients are also pleased with a new role: someone who can educate and save lives in their own communities. Staff report a new way to connect with clients that has a galvanizing effect on the therapeutic relationship. OD-related trauma can affect the recovery process.

Medico-legal

Barrier	Response
Nonmedical personnel are not authorized to distribute prescription medication* and are not authorized to administer a prescription medication to a person who has not been prescribed the medication *(*only a barrier in a distribution & standing order models)*	Prescribing of naloxone in the USA is fully consistent with state and federal laws regulating drug prescribing. (1) The standard of care for the use of naloxone has included for decades use by pre-hospital personnel who are operating under standing orders from physicians who are neither on-site nor directly supervising. A local public health regulation was passed by the City of Boston's board of health identifying the OPND program as an official public health program. Later, the General Council of the MA Dept of Public Health's Legal Opinion is that a statewide pilot can be established by policy under existing Laws and Regulations. (2) Life saving prescription medications, such as epinephrine injectors, and other devices, such as automated external defibrillators, are used by nonmedical personnel and bystanders. (3, 4) A study of 6 OPND programs has demonstrated that trained potential OD bystanders are similarly skilled as medical experts in recognizing OD and when naloxone is indicated. (5) States such as New Mexico, New York, Connecticut and California, have addressed this by passing laws that limit the liability of medical and nonmedical personnel who administer and distribute potentially lifesaving medication.
Intranasal delivery of naloxone is an off-label method (*only a barrier with the use of IN naloxone)	Prescriptions drugs may be and are routinely prescribed for any indication not explicitly prohibited by law. (1) Intranasal naloxone has been evaluated in several research studies and shown to be safe and effective, with little evidence of adverse events. A large scale randomized clinical trial is necessary to further confirm these findings. (6-10) Intranasal naloxone is a first-line treatment for opioid overdose among emergency medical personnel in the Boston community.
There is concern that providing naloxone increases liability.	The risks of malpractice liability are consistent with those generally associated with providing healthcare, and can be further minimized by following simple guidelines (see Burris, 2001 for guidelines)

Resources & Links

- A comprehensive literature review can be accessed at: http://www.hcsm.org/sphere/ODPrevention/research.htm
- North Carolina Medical Board position statement: http://www.ncmedboard.org/position_statements/detail/drug_overdose_prevention/
- MA statewide treatment provider survey report: http://www.hcsm.org/sphere/ODPrevention/pdf/SPHERE_Overdose_Prevention_Online_Survey_Final_Report_5-2-08.pdf
- There are many overdose prevention models in the country. Consider looking into them to locate materials, publications, anecdotes, lessons learned, and local resources. Just a *few* examples are:
  - sites.google.com/site/nomadoverdoseproject/home
  - www.harmreduction.org/
  - www.baltimorehealth.org/stayingalive.html
  - www.nyhealth.gov/diseases/aids/harm_reduction/opioidprevention/
  - www.anypositivechange.org
  - www.pppgh.org/

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