

**Getting on with our job**

**ATODA**

Alcohol Tobacco & Other Drug  
Association ACT

**Community development, priorities, staged approach:**

**Implementing expanded naloxone availability in the ACT**

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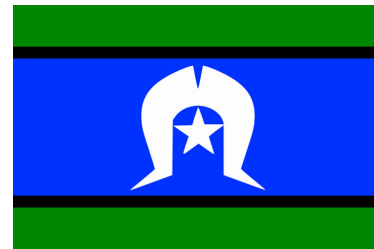
Presentation at the Centre for Research Excellence into Injecting Drug Use Colloquium

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[www.atoda.org.au](http://www.atoda.org.au)

I acknowledge the traditional owners and  
custodians of the land on which we meet, and  
pay respect to their Elders, families and  
ancestors

I extend my respect to all the Aboriginal and  
Torres Strait Islander people who are here today



I acknowledge the people who have lost their lives to, and have been injured by, overdose and the friends, families and communities who have been touched by overdose

We can save lives and prevent injury by implementing opioid overdose education programs, expanding naloxone distribution & building community capacity

# Introduction

- ATODA peak body representing NGO & Gov ACT sector
  - Seek to prevent and reduce harms from alcohol, tobacco and other drugs
  - Evidence-informed, public health, social justice, human rights
- Sister peak of VAADA

## Presentation areas:

1. Community development
2. Big vision staged priorities
3. Governance and other implementation tools
4. You could start tomorrow...

# The ACT program is NOT a trial

- Initially thought trial needed, changed approach as we learnt more
- We don't need more trials
- **Being evaluated, as per good practice especially for new programs**
- Better understanding of opioid overdose & naloxone distribution in the ACT and Australian contexts
- Staged implementation, sustainability discussions
- Core program in the ACT alcohol, tobacco and other drug sector

# Opioid overdose prevention priorities

## Reduce the frequency of overdoses

### Reduce the number of overdoses by improving people's responses to overdoses inc. their peers

- Better understand overdose causes and populations
- Comprehensive overdose prevention and management education
- Expand naloxone distribution
- Strengthen opioid maintenance / substitution therapy
- **Build the capacity of affected communities to prevent and respond to overdose**
- Implement peer-based and other health programs (e.g. NSP)

e.g. Hall, WD 1996, 'How can we reduce heroin "overdose" deaths? [editorial]', Medical Journal of Australia, vol. 164, no. 4, pp. 197-8., and many others

# Traditional deficit approach

- Focuses on identifying problems and needs of populations that require professional resources
- Creates dependency on external resources & solutions
- Defines communities & individuals in negative terms
- Disregards what is positive & works well in particular populations
- Emphasis communicates failure, helplessness, low expectations
- Deficit approach is necessary to determine levels of needs, priorities and funding... *but needs to be complemented...*

**Often comes too late, intervening after the problem is already there rather than working to prevent it in the first place**

# Add strengths / assets approach

- Accentuates positive capability to identify problems, learn new skills & activate solutions
- Assumes people have existing competencies & resources for their own empowerment
- Focuses on what is working well to support the growth of individuals & communities
- Promotes **people as “co-producers” of health** rather than consumers of services guided by professionals
- Leads to less dependency on professional services, need for scarce resources

**It makes sense to use a strengths / asset approach when working with communities to prevent & reduce harms**



# Community development / driven

- When existing groups of people in a community (rather than professionals) drive change and enhancement
- Community-driven initiatives happen when the internal assets of the community are the priority
- And when the existing resources (that build upon the effectiveness and power of the community) can be multiplied and sustained
- Builds resiliency to cope with challenges or stress in ways that are effective
- Results in increased capacity to respond to future adversity

**So what does this have to do with opioid overdose and expanding naloxone availability?**

# The argument

*Outside of MSIC, professionals won't likely be there when an overdose happens*

- People who inject drugs commonly experience overdose
- People in sub-populations are at increased risk of overdose (e.g post prison and detox release)
- Overdoses are often witnessed by people who can respond
- Peers, family members and others can successfully respond to assist in the management of overdoses among people who inject drugs
- Peers and family members are keen to respond to overdoses if they occur

# The ACT program is peer led

- **Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)**
- **The Connection – Peer Based Indigenous Drug User Service**
- ACT peer based drug user organisation
- Work within harm reduction framework
- Professional, expert, evidence-informed
- Members of communities frequently affected by opioid overdose
- Strong, respected community networks
- Well respected and engaged in ACT drug policy
- Launched December 2011 by ACT Chief Minister & Minister for Health

# Why didn't it happen earlier?

No particular reason – we just didn't do it

Why are we doing it now? Because we worked out we can and we have an ethical and professional responsibility to do so

- Drug users are equal members of our community and should receive equal evidence based healthcare (e.g. insulin, epipen, heartstart, etc.)
- Accept:
  - Actively engage with and contribute to the evidence
  - **Naloxone is fit for purpose**
  - Active drug use in our community
  - Chronic relapsing condition
  - People experience overdose (fatal and non fatal)
  - People's histories and risks after periods of abstinence
  - **The barriers are ours**

# Implementation ~~barriers~~ opportunities

	Before	Now
<i>Supply</i>	Global shortage, difficult to secure	Manufacturer in Australia
<i>Cost</i>	Expensive e.g. \$60	Cheap - listed on the PBS <u>\$5.90</u> (concession)
<i>Australian experience</i>	Emergency settings	Additional settings in ACT, NSW, SA and more on the way
<i>Australian tools</i>	Not really	Training programs, evaluation protocols, program descriptions, handouts, posters, forms, Q&A, media briefs, slides, templates, cards, etc. etc. etc.
<i>Illegal</i>	Wasn't	Still isn't
<i>Permission required by Gov</i>	Didn't need	Still don't – <i>but we should take stakeholders with us...</i>

# Game changer: naloxone on the PBS

- New listing on the Pharmaceutical Benefit Scheme in December 2012
- Naloxone hydrochloride 400 microgram/mL injection, 1 x 1 mL syringe (Naloxone minijet)
- Via prescription from a GP or nurse practitioner
- PBS \$36.10 / **Concession \$5.90**

# Implementing staged priorities

People who inject drugs currently attending overdose training

People who have experienced overdose, currently inject drugs, witnessing overdoses

People with histories of IDU leaving abstinence settings

People who are accessing opioid maintenance therapy

People who are prescribed other opioids, routine medical practice, etc.

Whoever needs / wants naloxone can affordably access it

# ACT delivery in varied settings





# Tool: ENAACT

*Professor Simon Lenton gets the name credit!*

- Expanding Naloxone Availability in the ACT (ENAACT) Committee established in 2010 to lead the process of developing a program to expand naloxone availability in the ACT
- Membership e.g:
  - Canberra Alliance for Harm Minimisation and Advocacy
  - ACT Ambulance Service
  - Pharmacy Guild of Australia (ACT branch)
  - AOD Policy Unit, ACT Health
  - Burnet Institute
  - Interchange General Practice & ACT Medicare Local
  - National Drug Research Institute
  - Social Research & Evaluation
  - Winnunga Nimmityjah Aboriginal Health Services
  - ATODA

# ENAACT-ing: Solutions

- Solutions focused and practical
- Shared, clear goals
- Key, clear roles with complementing skills and resources
- In kind commitment
- Realistic objectives and scope
- Focused on the research evidence
- Staged approach, acknowledge limitations
- Evaluation and learning process for all involved
- Agreed upon communication strategy
- Trust and confidentiality

# Implementation: I-ENAACT

- Local & national contact point to share information and support development
- Single reference point
- Oversight and support
- Supporting programs developments, including adapting to new technologies (e.g. minijet)
- Consistency & corporate knowledge
- Efficient use of very limited resources
- Changing and expanding membership

**All welcome!**

# Think big, start small

*The ACT program started with 1 GP*

- Develop, implement and evaluate programs to work within existing 'rules' (e.g. legislation)
- May not be ideal, but it's a start
- Will likely take years before programs get to ideal rollout

Hopefully, there will be a long-term policy, program, legislative, etc. development related to naloxone distribution and opioid overdose education, prevention and management in all jurisdictions in Australia

**Programs can improve and expand over time**

# Identifying assets

- What resources in Victoria can be built on?
- Are there affected communities who are interested in engaging in opioid overdose education which includes prescription naloxone?
- Are there people who know about this medicine and want access to it?
- Are there existing opioid overdose education programs?
- Could naloxone distribution be built into them?
- If only one program with one community could be implemented (within mostly existing resources) who would it be with?

# Tools available for your use

- Question & Answer
- Governance Group Terms of Reference
- Program description
- Media brief
- Submissions & briefs
- Research summaries
- The case for wider distribution of naloxone
- Training program (endorsed by ACT Government)
- Handouts
- Forms
- Presentations
- Newsletter articles
- Etc.

# You could start tomorrow...

**Do comprehensive opioid overdose prevention and education programs which include the prescription of naloxone work?**

**YES**

**Do we need more evidence before we get on  
with implementing programs? NO**

**We have enough evidence, we need to get on with evaluating  
implementation**

**A medical officer or nurse practitioner  
can prescribe naloxone today**  
*(recommended as part of a comprehensive program)*

# ACT program acknowledgements

- CAHMA, ACT program leaders
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Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Committee and stakeholders:

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- Mr David McDonald, Social Research & Evaluation
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- AOD Policy Unit, ACT Health
- Mr Phil Haber, Mr Chris Lawler, Mr Bill Arnold
- ACT Ambulance Service
- Mental Health, Justice Health and Alcohol and Drug Services, Health Directorate
- Winnunga Nimmityjah Aboriginal Health Service
- ATODA

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across Australia and around the world*