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OVERDOSE PREVENTION SERVICES UPON RELEASE FROM PRISON

ESTONIA, LITHUANIA, HUNGARY,
POLAND AND ROMANIA

 **Report**



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OVERDOSE PREVENTION SERVICES UPON RELEASE FROM PRISON

BEST PRACTICES FROM SCOTLAND,
DENMARK, ITALY AND SPAIN

 **Fact Sheet**



GILL BRADBURY, NEIL HUNT, DANNY MORRIS

**MODELS OF
COMMUNITY
AND PEER-BASED
OVERDOSE
PREVENTION
SERVICES:**

SCOTLAND, DENMARK, ITALY,
SPAIN, ESTONIA AND LITHUANIA

Comparative Analysis Report

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Eurasian Harm Reduction Network

The Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programmes, groups of people who use drugs and their allies from across 29 countries of Central and Eastern Europe and Central Asia (CEECA) who work to advocate for the universal human rights of people who use drugs in order to protect their lives and health. EHRN's mission it is to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and well-being, while protecting human rights at the individual, community and societal level.

NGO with Special Consultative Status with the Economic and Social Council (ECOSOC)

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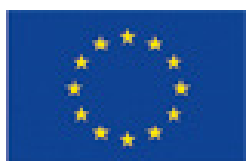
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ABBREVIATIONS

EMCDDA	European Monitoring Centre for Drugs & Drug Addiction
EHRN	Eurasian Harm Reduction Network
EU	European Union
IEC	Information, Education & Communication
NSP	Needle & Syringe Programme
OST	Opioid Substitution Treatment
THN	Take-Home Naloxone
UNODC	United Nations Office on Drugs & Crime
UK	United Kingdom
WHO	World Health Organization

EXECUTIVE SUMMARY

This comparative analysis offers some good practice examples for the two countries in question: Estonia and Lithuania. Indeed, Estonia is already using the Scottish model in the development of its overdose prevention and management programme, including take-home naloxone. This will enable increased confidence in the programme, since Scotland has been successfully providing such a programme for three and a half years.

However, Lithuania has no current plans to introduce such a programme, although it can endeavour to ensure that appropriate information, education and communication (IEC) materials are widely available and distributed within drug treatment, harm reduction and other relevant services, alongside overdose prevention protocols being in place for all services, as per the Catalanian model.

Italy reports over-the-counter availability of naloxone, and this would be an ideal situation for all overdose prevention and management programmes, including those in Scotland. Unfortunately, information on models of delivery was not available for Italy, and we were unable to comment on this in more detail.

Denmark primarily utilizes peers (i.e. people who use drugs) within its programme, and this has been shown to be an effective way of reaching more vulnerable populations. Scotland also uses peers extensively, and peer education approaches to brief interventions training and naloxone distribution deserves wider implementation to ensure comprehensive delivery of any overdose prevention and management programmes. Both Estonia and Lithuania should consider how they can best employ the services of peers, even if this only means facilitating them in the design and dissemination of IEC materials.

Denmark recommends the use of more simplified equipment such as pre-filled syringes or intranasal naloxone sprays which spray a fine mist into the nostril which is rapidly absorbed through the mucous membranes into the bloodstream. The intranasal device enables a non-invasive, fast, safe and painless method of delivering naloxone directly into the bloodstream, without the need for intramuscular injection which can present a barrier, as some people do not feel comfortable giving injections or may fear needle-stick injuries, particularly in an emergency situation.

TERMS OF REFERENCE

In 2013 a two-year project, 'EuroHRN II: Supporting Innovative Measures to Address the Reduction of Drug Related Harm in Europe', funded by the European Commission, was launched by Harm Reduction International (HRI). As one of the implementing partners, Eurasian Harm Reduction Network (EHRN) was responsible for the implementation of 'Workstream 2' – the 'I am the evidence' campaign – raising awareness of overdose while encouraging pan-European collaboration and information-sharing on overdose prevention.

This report comprises a comparative analysis of legislation, statistics and public health responses to opioid-related overdose in Scotland, Denmark, Italy, Spain, Estonia and Lithuania, as well as recommendations for adoption of good practice policies including collation of documented best practice.

It will take into account community-based overdose prevention and management programmes in these countries – particularly those which currently support peer distribution of naloxone.

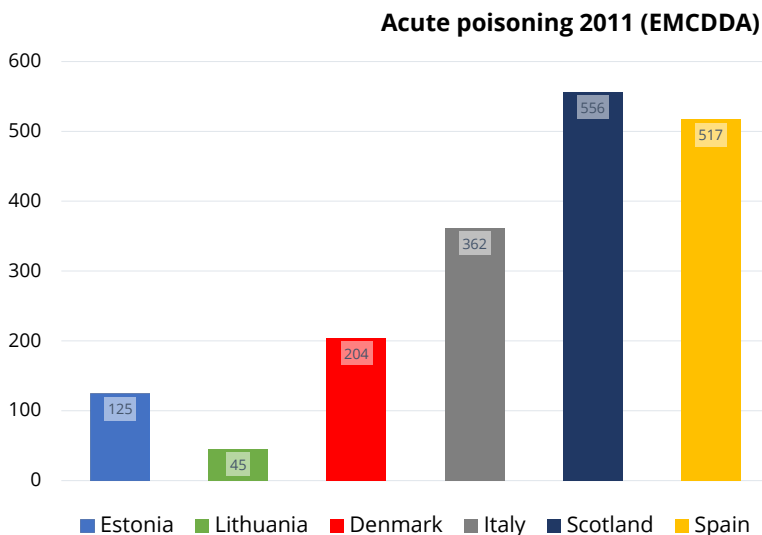
METHODOLOGY

The following set of data collection methods were agreed between the consultant(s) and EHRN:

- a) **Consultant(s) reviewed** (in consultation with EHRN) **EHRN methodologies of previous mapping** exercises and determined whether they could be adapted to this work.
- b) **Desk review of literature** and documents: the **consultant(s) conducted a desk review** of existing publications, documents and other materials that relate to the project topics and deliverables, as outlined above.
- c) **The consultant(s)**, with support from EHRN, **consulted with partners of the EuroHRN II project** as an information resource, and sought advice from them on relevant documents and organizations at the national level.
- d) **Interviews** (by telephone and skype) were carried out with key individuals and organizations in the target countries to gather information about existing programmes and best practices.
- e) **Templates and structures** for mapping deliverables were suggested by the consultant(s), then discussed and approved with EHRN.

INTRODUCTION AND DATA LIMITATIONS

The European Monitoring Centre for Drugs & Drug Addiction (EMCDDA) Data Sheet and Situation Summary inform much of the content of the country profiles in this report. Up until 2012 the EMCDDA defined 'problem drug use' as injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines. Information was also obtained from various other EMCDDA reports – i.e. the Annual Report, The State of the Drugs Problem in Europe (EMCDDA, 2012a) and the Preventing Overdose report (EMCDDA, 2012b) – as well as the report on the Current State of Play of the 2003 Council Recommendation on the Prevention and Reduction of Health-Related Harm, associated with Drug Dependence in the EU and Candidate Countries (European Commission, 2008).



Drug-related deaths are a major cause of mortality in Europe, particularly among people aged between 15 and 49. Opioids are present in the majority of drug-related deaths reported in Europe, and a substantial proportion of all drug-induced fatalities occur in a context of poly-drug use. One study found that between 10% and 23% of drug-related deaths in the above age group could be attributed to opioid use (Bargagli, Hickman et al., 2006). In 2006 the UK and Germany accounted for half of all reported deaths.

Besides heroin, a range of other opioids are found in toxicological reports, including methadone and, more rarely, buprenorphine. In Europe, while evidence of deaths resulting from the use of prescribed opioid analgesics remains limited, most overdoses in Estonia are linked to synthetic opioids, such as illegally produced 3methylfentanyl. This necessitates the close monitoring of changes in patterns of drug use that may be associated with elevated risks of mortality.

Men account for most overdose deaths reported in Europe (80% overall), and patterns differ between countries, with a higher proportion of males reported in several countries including Italy, Estonia and Lithuania, while Denmark and Spain report higher proportions of older people dying. In the majority of countries the average age of those dying from an overdose is mid-30s, and in many countries the average age is increasing. This suggests a stabilization or decrease in the number of young heroin users and an ageing cohort of opioid users. Overall, 11% of deaths reported in Europe occur among those under 25 years, and 57% among those aged 35 and over.

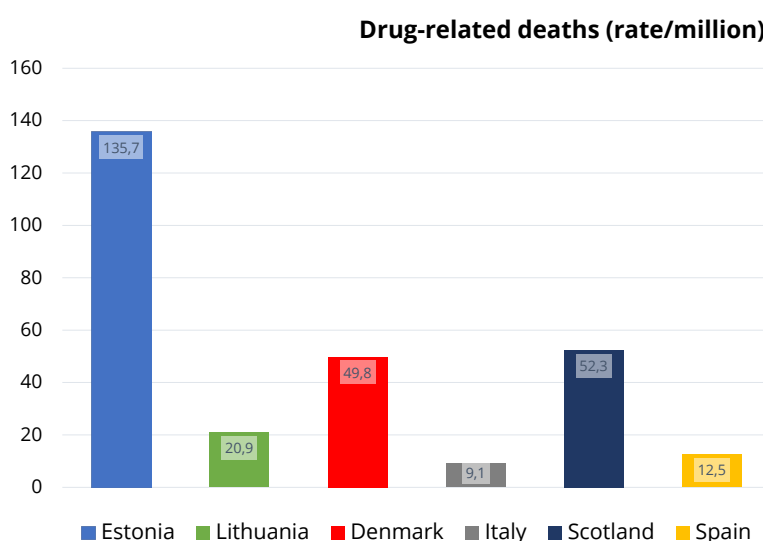
A number of factors are associated with heroin overdoses, both fatal and non-fatal. These include injection of drugs, simultaneous use of other depressant drugs (in particular, alcohol and benzodiazepines), psychiatric co-morbidity, previous experience of overdose, not being in

drug treatment, and homelessness. There is also increased risk of death associated with being alone at the time of overdose.

Figures on drug-related deaths can be difficult to interpret due to the different definitions and limitations of some monitoring systems. Indeed, data on such deaths sometimes encompass deaths caused by all types of poisoning (with a lack of toxicological screening data) and other types of drug-related deaths, including deaths caused directly or indirectly by the use of drugs. In addition to deaths from overdoses (drug-induced deaths) this includes mortality related to HIV, Hepatitis C, accidents, violence, suicide and chronic health problems caused by repeated use of drugs.

Some countries show a low detection rate of overdose in the general mortality registries, with a significant proportion of deaths recorded as being of unknown cause or an insufficiently specified cause (such as respiratory failure). Some of these deaths are likely to have been caused by opioid overdoses.

Therefore, assessing trends in the newer European Union (EU) Member States and candidate countries is problematic, as the number of reported deaths is small, and improvements in reporting capacity may reduce the comparability of data over time. Despite these difficulties, an increase has been observed in the mortality rate linked to drug-induced deaths in **Estonia** and, to a lesser extent, in the Czech Republic, **Lithuania, Hungary, Croatia** and Turkey.



Some countries have begun to talk about 'drug-induced death', which may better describe the type of death but still incorporates those deaths by other drug poisoning/overdose and not just those relating to opioid overdose. Given the fluctuating trends in drug-related deaths in some countries, it is not yet possible to establish whether preventative measures have had any impact.

Equally, until all monitoring and evaluation systems become more refined and consistently scrutinized, and when some degree of data recording parity is reached between service providers, it will be difficult to measure outcomes. Thus, there is a crucial need for common standards.

Scotland has one of the most developed overdose prevention and management programmes in Europe, including take-home naloxone (THN), and its models of delivery should be referred to for best practice examples. The programme has government commitment, public health funding, strategy and policy; nationwide coverage in various community settings (i.e. harm reduction and treatment services, pharmacies, and outreach); and ongoing developments including positive work in prisons and pending work with general practitioners (primary healthcare providers), much of which involves peers in the planning and delivery.

In considering community-based responses to overdose, one cannot ignore the fact that release from prison is associated with increased mortality from drug overdose. This risk does not appear to have decreased in the last 20 years (WHO, 2010). This is a critical time for action, when ensuring continuity of care and targeted interventions can both support treatment

engagement and save lives. It is, therefore, vital that there is cooperation between community and prison services, to ensure support and a seamless transition into community treatment. The term 'throughcare' refers to arrangements for managing the continuity of care before, during and immediately after custody, to facilitate a smoother and safe transition.

ADDITIONAL CONSTRAINTS OF THE EUROHRN II PROJECT METHODOLOGY

One of the biggest difficulties encountered is related to translations. Most of the documents that had to be reviewed are in the national languages of the focus countries, and in some cases translation of the literature was required (i.e. Denmark, Estonia, Italy and Spain). No budget had been allocated for this, so a combination of Google Translate alongside support and guidance from national contacts was used.

In addition, just one or two people were identified from each of the countries for interview. In Denmark identifying a contact person took longer than planned, and arranging interviews in some countries took up to five weeks after initial contact was made. Moreover, the interview in Italy was compromised because the interviewee had a limited understanding of English, and identifying alternative English-speaking contacts had been unsuccessful.

This lack of capacity to translate interviews and resources affected data collection. Access to Spanish contacts and data was difficult too, and we have been unable to obtain a response from Spanish National Programme representatives, although additional support was gained from the Public Health Agency for Catalonia; therefore, much of the section regarding Spain refers to the programme in Catalonia.

Furthermore, the timeframe for activities was not sufficient: a vast amount of information relevant to the assessment was identified, but not all of it could be reviewed and included due to a lack of time. This was addressed by clearly defining tasks and limiting the assessment to respond to what has been described in the project.

Finally, some of the information provided by interviewees differed from data obtained elsewhere, and when cross-referencing reports there are discrepancies between some of the data.

KEY POPULATIONS AND PEOPLE MOST AT RISK OF DRUG-RELATED DEATH

All the population groups listed below face further stigma and discrimination – a secondary degree of marginalization. They frequently experience difficulties in accessing and engaging with community-based services. Thus, they require sensitive consideration when implementing overdose prevention and management programmes, including THN and other treatment.

Women: Women are at risk of overdose for a range of socio-economic reasons. Variations in vulnerability exist within different countries, although many have experienced trauma related to physical abuse, sexual abuse and violence, while also having mental health co-morbidities (WHO, 2009). In addition, the risk of drug-related death is particularly acute among women newly released from prison (Farrell and Marsden, 2008).

Young people: While evidence shows that most overdoses occur in older males, in the Member States that have joined the EU since 2004, drug-related deaths are more likely to occur in younger people. Overall, 11% of overdose deaths reported in Europe occurred among those aged under 25 years. Some young people can be said to be at risk of overdose due to their lack of experience and lack of specialist services, as well as increased incidence of certain drugs, such as fentanyl in Estonia.

Migrants/foreigners: Migrants may be unaware of services available within the community and may have difficulties accessing/engaging with them, due to cultural, gender and language barriers.

Roma populations: The Roma people are widely discriminated against throughout Europe. Such marginalization makes them less likely to access services and receive treatment (which is, potentially, a protective factor). Equally, drug problems are likely to be hidden in such families, so people who use drugs in Roma families are not encouraged to seek treatment.

Homeless people: People who are homeless are at particular risk of overdose and drug-related death. Equally, they are less likely to engage with services and are further marginalized. Their patterns of drug-using behaviour may be more dangerous because of environmental conditions and as a result of using in unsanitary public places.

People living with HIV and TB: Some of the focus countries have high rates of HIV and TB infection among people who use drugs. These populations often have poorer general health, and some illicit drugs can interact with antiretroviral and TB medications; this may make people more susceptible to overdose due to compromised physical health and metabolism issues.

Psychiatric co-morbidity/dual diagnosis: This is the presence of both a mental health and substance use problem which particularly affects vulnerable groups including people who use drugs (and prisoners). This dual diagnosis represents a serious risk factor for suicide and, potentially, more careless drug use.

Lesbian, gay, bisexual and transgender (LGBT): Drug use is widespread within these communities. However, due to additional issues around stigma and discrimination, LGBT people may not access services unless specifically targeted. Increased efforts need to be made

to engage this population in drug services, per se, and also naloxone distribution programmes.

Prisoners: For prisoners with a history of opioid use, the risk of dying from drug overdose greatly increases in the period following release from prison, due to high rates of relapse and lower opioid tolerance. This is a critical time for action, when ensuring continuity of care and targeted interventions can both support treatment engagement and save lives.

POPULATION

The delivery of drug treatment is through local multi-agency partnerships representing health, criminal justice agencies and social care services. Local authorities across the UK are expected to provide a comprehensive range of services, including information and advice, screening, needle and syringe programmes (NSPs), opioid substitution treatment (OST), psychosocial treatment, detoxification and residential rehabilitation.

OST remains the main treatment in the UK for opiate users. Oral methadone is generally the drug of choice, but buprenorphine has also been available since 1999, and a combination of buprenorphine and naloxone (suboxone) is also being used. In Scotland there were 22,224 clients receiving methadone treatment during 2006/2007 (*more up-to-date statistics on opioid use and OST in Scotland are not available*).

OVERDOSE EPIDEMIOLOGY

The rate of drug-related deaths in Scotland remains higher than the UK average, with 10.58 drug related deaths per 100,000 population in 2011, compared with 2.83 in the UK as a whole.

The second report from the National Drug-Related Deaths Database in Scotland was published in early 2012 (Graham, Stoner et al., 2012). The drug-related deaths in the report are a sub-set of the 485 drug-related deaths recorded in Scotland for 2010 (GROS, 2011; Davies, English et al., 2012). It examined the personal circumstances behind the deaths of 365 individuals and showed that:

- the majority of cases were male (79%);
- 83% of deaths occurred in the under-45 age group;
- where known, 62% (i.e. 214 individuals) who died of a drug-related death had previously been in contact with drug treatment services;
- of these, 143 cases had been in contact with services in the six months before death, and 90 individuals in the four weeks before death;
- over half of them (n = 124) had been in contact with either a general practitioner or drugs service at least 12 weeks before their death;
- over half (i.e. 199 people) were known to have injected drugs;
- one third (38%) had children under 16 years of age, and 8% (29 people) lived with a child at the time of their death; and
- over half of those who died lived alone.

Being able to identify this type of data enables a strategic approach, leading to more effective targeting of vulnerable populations of people who use drugs, alongside a focus for efficient planning and development of overdose prevention and management programmes nationwide.

LEGISLATION

In the community, medicines are normally supplied to a named patient only. Naloxone is an injectable Prescription Only Medicine (POM) under the UK Medicines Act (1968). This means that it can only be supplied to a named patient, using either a prescription or a Patient Group Direction (PGD). A PGD is a legal mechanism that allows suitably qualified nurses or pharmacists to supply POMs in specific, defined circumstances.

There is a limited list of exceptions to this, and in 2005 naloxone was added to that list. Therefore, although supply must be to a named person, in the event of a suspected opiate overdose **anyone present** at the scene can legally administer that supply of naloxone **to anyone** to save a life.

Access to naloxone is not restricted to people receiving treatment either; it is available to anyone that the nurse/pharmacist identifies as being at risk of overdose, irrespective of current or previous contact with treatment services.

In March 2011, legal guidance from the Lord Advocate allowed the supply of naloxone by PGD “to extend to staff working for services in contact with people at risk of opiate overdoses” (e.g. homeless hostels, shelters etc.) so long as the staff member has completed the naloxone training programme. When a supply is issued to a named care worker, it is not intended to be their personal supply. The individual is receiving the supply on behalf of the service for storage and use within the service. If the staff member leaves the service, then the supply of naloxone should stay within the service.

PUBLIC HEALTH RESPONSES – CURRENT OVERDOSE PROGRAMMES

In Scotland there is a National Drugs Strategy (Scottish Government, 2008), and the overall programme is funded by the Scottish government (Public Health Scotland), which is essential for the development of a national programme.

The aim of the National Naloxone Programme (the National Programme) is to contribute to a reduction in fatal opioid overdoses in Scotland (both in the community and after release from prisons). As mentioned above, the rate of drug-related deaths in Scotland remains higher than the UK average (10.58 drug-related deaths per 100,000 population, compared with 2.83).

An earlier investigation into drug-related deaths in Scotland and more recent information from the National Drug-Related Deaths Database have shown that the majority of these deaths are opioid related; the majority are ‘accidental overdoses’; the majority are ‘witnessed’; and around half of those people who died have spent time in prison (Zador, Kidd et al., 2005; Graham, Stoner et al., 2012; Hoolachan, Hecht et al., 2013).

All but one (13 out of 14) Local Health Boards opted in to the National Programme, although there are some regional variations with regard to delivery methods. Having this national infrastructure, collaborative commitment and integration is critical to the evolving success of such a programme.

“ If you trace the history of the training programme, we’ve come from a starting point of delivering half-day sessions, and now it is done in 10 minutes. It’s amazing how it’s changed over time, but we had to go through a lot of learning before we got to that point... From a risk management perspective we had to demonstrate that all these things could be done in the right way before we were able to streamline it. ”

Andrew McAuley
*Public Health Adviser (Substance Misuse), NHS
Scotland*

are then supplied by community pharmacists.

Peers are trained to train people who use drugs in the community via a ‘brief intervention’ model (particularly for those attending NSPs). Those who are trained are then issued with proof of training cards, which can be presented to any service or pharmacist that supplies naloxone.

For quality assurance purposes, the dispensing nurse or pharmacist goes through a quick checklist to ensure competency, before supplying the naloxone. There are examples of some pharmacists having a peer educator on site to deliver training, after which the pharmacist then dispenses the naloxone.

The next phase of the THN programme is to develop naloxone distribution within general practices (primary health care centres) over the next 12 months. The second report from the National Drug-Related Deaths Database in Scotland indicated that, of 365 drug-related deaths, over half of those individuals had been in contact with either a general practitioner or drugs service at least 12 weeks before their death.

This is, therefore, a missed opportunity and has the advantage of attracting some of those being released from prison. All these interventions have the potential to make a significant impact on Scottish drug-related deaths, if the roll-out of these programmes continues and uptake is deemed a success. The delivery of the National Programme is currently being independently evaluated, which will include prison interventions.

The Scottish government has committed funding until the end of 2014. Since results have been good thus far, it is hoped that there

The National Programme in Scotland has been developing over the last three and a half years, and its successful delivery depends on both multi-disciplinary professionals and trained peers from communities of people who use drugs. This has now extended to involving peers in prison in providing overdose prevention and management training to other prisoners who have a history of opioid use.

There is extensive national coverage – with training and distribution being delivered through various community settings (harm reduction and treatment services, pharmacies and outreach) – often via a peer delivery approach.

The majority of areas deliver primarily through harm reduction teams and drug treatment services, although there are exceptions if nurses are not employed within these services – the clients are trained within the service but

“ You really need that national infrastructure – without that it’s difficult. People can feel a bit isolated; that’s effectively what you have down south (England). We get a lot of contacts, requests, emails for information from local leads in England, as they don’t have that national resource. ”

Andrew McAuley
*Public Health Adviser (Substance Misuse), NHS
Scotland*

will be a continuation of funding. In terms of public health improvement, the budget does not represent a significant amount. The support of Public Health Scotland is both positive and proactive; it takes on an advisory role in terms of evidence and research and connects with other partners to offer a public health face to the programme – for example, leading on engagement and development with general practitioners for THN.

Public Health Scotland has established a monitoring and evaluation system for the National Programme, from which reports are generated and reviews of efficacy are undertaken. The organization also coordinates and commissions new areas of work, such as research etc., while working with the Scottish government to assist the Drug Action Team, Local Health Board and third-sector roll-out of the programme. The National Naloxone Programme is recognized as a model of good practice and is also supported by the practitioner network and advisory groups.

EFFECTIVENESS AND BENEFICIARIES		
Number of naloxone peer networks	8	<i>This number includes prison peer networks</i>
Number of community peer trainers	67	<i>Some drop out, but most are still there</i>
Number of community take-home naloxone (THN) kits issued (2012/13)	3833	10.8% increase on previous year 80% First supply 18.1% Repeat supplies 1.8% Unknown
Number of community THN kits issued (2011/12)	3458	83.8% First supply 12.8% Repeat supplies 3.5% Unknown
Gender distribution 2012/13	65.2% 34% 0.8%	Male Female Unknown
Age distribution 2012/13	8.5% 42.8% 47.8%	Under 25 Aged 25–34 years Aged 35 and over
Percentage of people who inject drugs supplied with naloxone (2012/13)	20%	86.8% = 2680 kits to people at risk of overdose 10.7% = 329 kits supplied to service workers 2.5% = 78 to family/friends – consent gained
Number of overdose reversals (2 years)	365	<i>Under-reported incidences of overdose reversals</i>
Consent to recording of personal data	98.7%	Worth noting that most people do not object to such data being collected!
Comparative uptake of THN	375	More kits distributed in 2012/13. This includes kits issued in both the community and prisons.

Please note: Most data relate to kits issued rather than individuals and, therefore, include repeat kits. However, **293 people trained by peer trainers** and **204 kits issued to people trained by peer trainers** (where known).

OTHER REFLECTIONS – SUCCESSES AND CHALLENGES

- In both December 2012/13 and 2011/12 the largest number of kits supplied in the community was recorded, coinciding with festive overdose prevention campaigns – the festive period being recognized as a high-risk period for people who use drugs.
- Engaging professionals and peers together in training and service delivery has many benefits and contributes to reducing stigma and discrimination, while informing a deeper level of understanding in the community.
- The programme has the benefit of evolving over time, which has enabled interventions to become more streamlined and efficient, typically now 15-minute ‘brief interventions’. The National Programme has been able to demonstrate good governance in its delivery procedures.
- The government has commissioned a ‘process evaluation’ which is underway to identify best practice, barriers and enablers to further roll-out and, if possible, any other behaviours that have been influenced as a result of training and the use or impact of naloxone.
- The Lord Advocate’s guidelines relaxed regulations governing naloxone to permit non-health professionals in settings where people may be at risk of overdose (e.g. homeless hostels, shelters etc.) to hold it on-site. This guidance on naloxone is totally unique in allowing a prescription-only medicine to be supplied to a service which would not normally store ‘stock’ medication.
- In most areas, naloxone is not routinely supplied to all of those receiving OST. Some areas are trying to ensure that it is prioritized and normalized. If successful, the reach and coverage would greatly increase. This is an evolving area of work which offers further opportunities.
- It has long been recognized that families are a crucial component in an effective response to overdose prevention and management. However, family and carers cannot be supplied with naloxone without the explicit consent of the individual at risk – which presents a fundamental barrier, although some people are willing to provide consent.
- Many families have been keen to get involved in the programme, but there are lots of ethical and human rights issues about giving medication without consent. Families can, of course, and are encouraged to, receive the training, as this remains a crucial element for recognizing and dealing with an overdose promptly.

PEER INVOLVEMENT

Peer work is innovative, and five Local Health Board areas have adopted a peer model with ongoing peer-to-peer training occurring within harm reduction/NSP and drug treatment services, as well as in outreach settings. A nurse or pharmacist is called on or referral made for the dispensing of naloxone at the end of the training. This is a growing area and usually involves people who are attending a drug service. The service will identify peers who will then undertake a skills-based assessment and peer-led training as appropriate. The ability to engage with the training programme is the main factor. Peers include people who use drugs, people with a history of using drugs and also family members.

The training of peer trainers involves a half-day of drugs awareness (including issues in relation to stigma and discrimination), followed by two days of overdose prevention and management (including naloxone) training for trainers. The same content is delivered for the staff training, with a further half-day spent on monitoring, evaluation and the practical skills on how to roll out a programme in the community.

“ TRAINING OUTLINE

Training for delivery of the naloxone distribution programme covers:

- why there is a need for naloxone?;
- the drugs involved in opioid overdose;
- risk factors for opioid overdose;
- how to recognize an overdose; and
- what to do and what not to do.

This is followed by a practical skills session, which teaches people how to inject naloxone, how to administer basic life support and how to place someone into the recovery position.

The naloxone is administered by intramuscular injection into the outside of the thigh through clothing. ”

Scottish National Programme

from each Local Health Board, usually a pharmacist or nurse. The National Programme would like to achieve at least one active peer network in each Local Health Board area. The Naloxone Training and Support Officer participates in a monthly meeting with the group for a minimum of six months after the training.

The National Coordinator can link peers with local naloxone steering groups, and, since re-establishing the National Volunteer Forum on Drug-Related Deaths (NVFDRD), members are also represented on this group. This feeds into the national forum on drug-related deaths.

Some of the peer trainers were also involved, with the local coordinator, in training the pharmacists – this served to increase individual credibility and enable some peers to deliver the training in pharmacies. The next phase will be working with general practitioners, which will ideally provide another good opportunity for peers to train peers, while the general practitioners only have to supply the naloxone.

All of this indicates involvement of peers at all levels of the planning and implementation of

The peer trains their peers in community settings, using a ‘brief intervention’ model of training, particularly for those attending NSPs – this encourages more people to engage. The client can receive sterile injecting equipment and be trained and supplied with naloxone in 10 minutes or so, depending on how knowledgeable, adept and capable they are.

There will be exceptions when clients need more time, and interventions are tailored to meet individual needs. More thorough basic life support training is still undertaken if requested (with a resuscitation mannequin). However, this aspect is generally delivered via written and pictorial materials during the brief intervention. Peer trainers are skilled enough to adapt to the person in front of them and determine the level of training required by the individual’s experience.

Peers in outreach settings can signpost to some NSPs or pharmacies for dispensing. Pharmacists involved in the programme generally receive a financial incentive to go through a very basic checklist to establish competency prior to dispensing the naloxone.

Services should be willing to actively support the peers in all their activities (which are simply recorded in a log book), and each peer network is linked to the local Naloxone Coordinator

overdose programmes.

This kind of peer engagement also has additional benefits in reducing stigma and discrimination – it allows professionals to appreciate the skills and commitment that peers bring, while informing a deeper understanding within the wider community.

Good partnership working is evidenced through the new patient clinic at one of the 'Community Addiction Teams'. A group of peers (i.e. both those on OST and those who are abstinent) facilitates training programmes, and the nurses on-site supply.

“ There is a very active outreach service in Edinburgh – whether on the methadone bus or via street patrols, the outreach workers go around with backpacks and do needle & syringe exchanges, and naloxone training – which is supplied on the streets. There is also good access to homeless people who use drugs. ”

Andrew McAuley
*Public Health Adviser (Substance Misuse), NHS
Scotland*

“ Intranasal naloxone

The delivery of naloxone in the National Programme is through intramuscular administration, except for Highland where both intranasal and intramuscular methods are employed. The intranasal approach was introduced as a pilot in 2012, due to perceived local problems with the licensing of the product and its delivery.

The intranasal device offers a non-invasive, fast, safe and painless means of delivering naloxone directly into the bloodstream, without the need for needles and intramuscular administration which can present a barrier, as some people do not feel comfortable performing an injection or may fear needle-stick injuries, particularly in an emergency situation.

In the UK currently, several NHS Ambulance Services Trusts are using the intranasal device to administer naloxone, but this will be the first time it has been used as part of a take-home service. ”

POPULATION

The latest available estimates, from 2011, show that 7600 clients were receiving OST, of whom 6200 were on methadone and 1400 on buprenorphine. In January 2010 the government initiated a scheme of treatment using medically prescribed heroin, offered to the 'most seriously affected' heroin users. There were 198 people receiving heroin treatment in April 2013.

OVERDOSE EPIDEMIOLOGY

Until 2011, drug-related deaths were registered in the National Board of Health's Cause of Deaths Register, and subsequently by the State Serum Institute. The register applies the European definition of drug-related deaths. It includes deaths caused by injurious use of drugs, addiction and drug psychoses, as well as deaths caused by intentional and unintentional poisoning.

According to the Cause of Deaths Register, in 2011 there were 285 drug-related deaths in Denmark. In 2010 there were 204 drug-related deaths, the lowest recorded number since 1995. Some 77.5% of drug-related deaths were males, and the mean age at time of death was 44.7 years.

LEGISLATION

Naloxone is used by the emergency services and in hospital settings. It is also available on prescription to those at risk of overdose.

The Danish Drug Users Union (DDUU) recommends that the prescription requirement for naloxone be removed and that the drug be made available over the counter.

PUBLIC HEALTH RESPONSES – CURRENT OVERDOSE PROGRAMMES

Denmark has a strong tradition of harm reduction, including outreach street work, drop-in centres, NSP and social support at home. NSPs have been established in Denmark since 1986, and there are high levels of access to clean injecting equipment across municipalities. These services are administered via pharmacy dispensing and sales or through dispensing machines, with clean injecting equipment available at public sites.

Some municipalities provide NSP through shelters and hostels – together, this offers increased links with hard-to-reach and vulnerable people, whereby some training around overdose prevention and management could also be undertaken.

Treatment for opioid users is mainly medically assisted (i.e. OST) and is accompanied by psychosocial counselling. In recent years, several initiatives to address socially marginalized people who use drugs, those with a dual diagnosis (i.e. drug use and psychiatric co-morbidity) and underage (youth) drug users have been supported – this too will afford improved opportunities for accessing vulnerable populations with overdose prevention information and naloxone supplies.

In 2010 Denmark initiated a one-year pilot project distributing naloxone in one Danish municipality to assess its relevance for wider scale-up. The City of Copenhagen collaborated with the DDUU as equal partners in the programme. The DDUU was instrumental in establishing the naloxone pilot and directly involved in its planning and development.

The City of Copenhagen funded the health centre to educate 28 peers to respond to an overdose situation. These peers (known as ‘overdose therapists’) were allocated several doses of naloxone to use in the community for overdose management, and 14 cases of overdose were reversed over a period of 10 months.

Based on recommendations from the pilot model, the programme is now being trialled in four or five of the larger cities across Denmark.

The Copenhagen project has demonstrated a simple and sustainable way to prevent overdose deaths in Denmark. Those engaged with the planning of the project believe that, by involving people who have daily/frequent contact with people who use drugs, environments which are otherwise closed to professionals can be accessed.

The Copenhagen project’s primary objective was to determine the structure and content of an overdose prevention course and how to deliver training to peers. Ongoing training, support and debriefing was also provided.

This project has successfully shown that overdose prevention and management is effective and efficient when it is delivered in close cooperation with the local drug environment – and as supported by numerous international studies.

“ The Copenhagen project has a high degree of user involvement at all levels:

- The DDUU is involved in the planning and development of materials to be contained in the overdose prevention kit;
- the overdose prevention kits are produced by people who use drugs; and
- continuous assessment of equipment and project design has been undertaken in collaboration with associated health professionals and other project stakeholders. ”

“ Involving people who use drugs increases access to environments which are otherwise closed to professionals – thereby enhancing access to people who may not be involved with treatment services... ”

Jorgen Kjaer,
Danish Drug Users Union

Since then, a community – i.e. local citizens with previous experience of setting up mobile injection rooms, initially with volunteers and then, subsequently, funded – has established its own naloxone project, Antidote.

The DDUU recommends that the prescription requirement for naloxone be removed and that the drug be made available over the counter. If not, the future development of overdose prevention and management programmes may be restricted by medical resources that are already scarce.

It was also agreed that the equipment should be simplified. This project used the pharmaceutical form, already available in Denmark and which has to be drawn up manually. However, other types of naloxone are available including pre-loaded syringes and an intranasal naloxone spray, which are generally much easier to use (but more expensive).

Similarly, the DDUU recognizes the value of other groups being trained, including family, friends and employees in shelters etc., as well as people who are receiving opioid analgesics for the purpose of pain management.

POPULATION

A total of 57,577 clients entered treatment in 2011, of which 33,679 were new treatment clients. Data indicate that 55.3% of all clients entering treatment reported primary opioid use. The most widely used OST in Italy is methadone (introduced in 1975), although the use of buprenorphine has been increasing since it was introduced in 1999. In 2011 there were 109,987 clients receiving OST, of whom 93,119 were on methadone and 16,868 on buprenorphine.

OVERDOSE EPIDEMIOLOGY

National data on direct drug-related deaths are collected by the Special Registry maintained by the Central Directorate for Antidrug Services (DCSA) of the Ministry of the Interior. Trends in drug-related deaths peaked in 1996, followed by a progressive decrease and stabilization between 2002 and 2007. Since then, a declining trend has been observed.

DRUG-RELATED DEATHS – *Special Registry maintained by DCSA*

2011	2010	2009	2008	2007	
362	374	484	517	606	Gender: 86.7% of deaths were male
					Mean age at time of death: 36.9 years

More than half of the drug-related deaths had toxicology testing results available, which indicate opiate overdose as the most prevalent cause of death. Total deaths represent 9.1 per million population.

LEGISLATION

Naloxone is used by the emergency services and is also said to be available over the counter in pharmacies.

PUBLIC HEALTH RESPONSES – CURRENT OVERDOSE PROGRAMMES

Some outreach programmes exist at a local level, operated by health and social care organizations (public and private), together with specific projects funded through the National Drugs Fund.

Both the outreach programmes and projects financed through this fund include NSPs and information dissemination. Harm reduction interventions are delivered through fixed sites, mobile units, outreach programmes and needle and syringe dispensing machines.

Naloxone is reported to be distributed in community settings via NSPs, outreach, drug services and pharmacies. However, we have been unable to find much evidence to support this, and more detailed models for service delivery are not available at the moment.

POPULATION

Between 1999 and 2002 several estimates of 'problem drug use' were made, applying the demographic and multiplier methods. In 2010 the number of dependent opiate users (heroin in particular) was estimated at 1.2 per 1000 inhabitants aged 15–64. This means that 38,500 dependent opiate users were estimated to be living in Spain in 2010.

There were an estimated 7393 people who inject drugs in 2010, based on treatment data, the majority of whom were using heroin or other opiates. Incidence estimation studies showed a sharp decline in the number of new heroin users.

In 2010 data on treatment demand were collected from 507 outpatient treatment centres (and treatment units in prisons). A total of 53,508 clients entered treatment in 2010, of which 26,805 were first-time treatment clients. Data indicate that 34.3% of those entering treatment and 18.2% of those who entered treatment for the first time were opioid users.

Injecting drug use has fallen dramatically in the past 30 years among those admitted to treatment, regardless of the primary substance. Thus, in 2010 only 15.8% of all opioid users admitted to treatment and 10% of new treatment clients reported injecting.

Poly-drug use is common among Spanish treatment clients, with around two thirds of treatment clients reporting the use of two or more substances within 30 days prior to admission for treatment. The single most important factor for fatal overdose appears to be the use of (other) depressant drugs such as benzodiazepines and/or alcohol at the same time as illicit opiates, and such risks and trends should always be taken into consideration.

In 2010 some 20% of all clients entering treatment were under the age of 25, while 45% were 35 years and over. Among new treatment clients, the proportions of those under the age of 25, and aged 35 years and over were similar, at 30% and 32%, respectively. In terms of gender distribution, 85.1% of clients entering treatment were male, and 14.9% were female. A similar gender distribution was also reported among new treatment clients (84.5% male and 15.5% female).

OVERDOSE EPIDEMIOLOGY

Since 1993 Spain has had a Special Registry based on forensic and toxicological sources that collects data on deaths caused by acute reactions to drugs in specific geographical areas (covering approximately 50% of the Spanish population).

Data are collected on deaths (with judicial intervention) where the direct and main cause is an acute adverse reaction after a non-medical and deliberate use of psychoactive substances (excluding alcohol and tobacco) among those aged 15–49. Since 2003 the age group registered has been expanded to cover those aged between 10 and 64 years.

In 2010 the Special Registry reported 517 drug-related deaths. In addition to the Special Registry, the Spanish General Mortality Register also provides information on deaths related to drug use. In 2010 the General Mortality Register reported 393 drug-related deaths. However, this registry is believed to underestimate by 40% the number of drug-related deaths when compared with the figures recorded in the Special Registry.

According to the General Mortality Register, the number of deaths due to an acute reaction to drugs fell between 1999 and 2001, remained stable until 2005 at approximately 670 and has since resumed a downward trend.

2010 DRUG-RELATED DEATHS	
517	Special Registry
393	Spanish General Mortality Register

Gender: 84% males
Mean age at time of death: 39 years

LEGISLATION

Naloxone is provided for treatment within emergency medical services, and to professionals working in some harm reduction centres and drug consumption rooms for supply to people who use opioids.

PUBLIC HEALTH RESPONSES – CURRENT OVERDOSE PROGRAMMES

Most specialist harm reduction programmes in Spain include a ‘socio-sanitary’ service that offers preventive educational interventions, overdose prevention and management activities, injecting equipment, emergency care and assistance to people who inject drugs who are not generally in contact with any support services.

Public outpatient clinics, and several NGOs, also carry out harm reduction activities. In 2011 a total of 1029 NSPs distributed about 2.7 million syringes. There were eight facilities for supervised drug consumption available in the following regions: Madrid (one facility), Catalonia (six facilities) and the Basque Country (one facility).

Provisional research suggests that there are no structured naloxone programmes across Spain to report on, although it has only been possible to obtain specific regional information on naloxone distribution in Catalonia, rather than confirm a national overview.

Therefore, the following description relates to an overdose prevention and management programme in Catalonia. All drug centres in Catalonia have protocols on overdose prevention and management; this includes hospital detoxification units, harm reduction services, OST centres and therapeutic communities.

Naloxone is only provided for treatment within emergency medical services, and in some harm reduction centres and drug consumption rooms. Drug consumption rooms are able to reach many with naloxone programmes, and the centres have public health targets to train people who use opiate/opioid drugs. People who use drugs are paid to attend the naloxone programme.

Initially, naloxone training programmes were extremely comprehensive but also quite rigid

and protracted; the training is now more flexible as confidence has grown, which is better for service users and encourages increased engagement with the programme.

In addition to this, it is reported that some peer educators who are former users work from apartments to distribute naloxone, but this is not a formal arrangement.

Naloxone is not available within therapeutic communities, although staff do offer overdose prevention advice and information about the risks of lower tolerance.

POPULATION

In 2010 a study to estimate the size and prevalence of people who inject drugs between 2005 and 2009 was conducted in cooperation with the National Institute for Health Development and the Department of Public Health, University of Tartu. The results indicate a decrease in the number of people who inject drugs of almost 56% during that period (from 14,262 in 2004 to 6266 in 2009).

According to the Estonian Drug Treatment Database, the number of clients who have received methadone has increased over the last few years.

OST TREATMENT IN ESTONIA				
2008	2009	2010	2011	2012
1008	1012	1064	1076	1157

However, the figures in this table contradict EMCDDA data which cite half as many people being in treatment – i.e. in 2011 a total of 532 clients entered treatment, of which 163 were new treatment clients, and in 2012, 546 clients entered treatment, of which 125 were new treatment clients. The drug treatment demand data in Estonia (2011) were based on 13 outpatient and inpatient centres (including two prisons).

Some 85.6% of those registered were opiate users (mainly fentanyl or 3-methylfentanyl). The figures for all individuals entering treatment show the same distribution: 93.4% were opiate users (mainly fentanyl or 3-methylfentanyl). Most drug treatment clients were receiving OST.

In 2012 some 18.1% of all clients entering treatment were under the age of 25. For new clients entering treatment the proportion of younger clients was considerably higher, with 39.2% under the age of 25.

With regard to gender distribution among those entering treatment, 77.5% were male, and 22.5% were female. A similar distribution was also noted among new treatment clients, with 72.0% male and 28.0% female.

Whilst all those organizations providing drug treatment should report to the database, not all of them do. Since the database is not personified (but coded), the data cannot be cross-checked. The National Institute for Health Development collects data on methadone maintenance treatment separately (as part of the funding procedure), and there have been discrepancies between the sources, which led to the decision to restructure the drug treatment database and make it personified. This is underway and will allow greater comparison and improved cross-checking of data.

Methadone detoxification has been available in Estonia since 1998, but although methadone maintenance treatment was officially introduced in 2001, it has only been used on a significant

scale since 2003, with the opening of a specialist centre. Nevertheless, treatment capacities still seem unable to meet the growing demand for OST in recent years.

The National Health Plan (2009–2020) aims to develop the professional capacities of staff and to improve the availability and quality of treatment services.

OVERDOSE EPIDEMIOLOGY

From the data available, it is not possible to estimate the number of opiate users at risk of overdose, and clearly OST can be a protective factor against overdose. There is no information available regarding the numbers of non-fatal overdoses (either witnessed or self-reported); equally, we cannot obtain data about emergency service attendances for overdose.

Data on drug-related deaths are only available for deaths caused by an acute intoxication of drugs. A total of 123 cases of direct drug-related deaths were recorded in 2011, fewer than in 2009, when 133 cases were recorded, but still exceeding the levels in previous years (101 in 2010; 67 in 2008; 68 in 2006; 57 in 2005; and 98 in 2004).

Heroin is not readily available in Estonia, and only in very small quantities – there is very little use of it. However, fentanyl is used extensively; this drug is associated with very high overdose rates because of its potency.

Opioids, 3-methylfentanyl in particular, were present in 95.9% of all deaths where toxicological results were known, and in many instances other psychoactive substances were also present.

With regards to the distribution of drug-related deaths by age and gender, the majority were men (87.8% cases), and the deceased were on average 30.1 years old at the time of death. No data are available regarding the ethnicity of people who died from overdose.

“ Even experienced users report difficulties in managing dosing of fentanyl, and the strength varies. Fentanyl is imported but, it is not a pharmaceutical product. ”

Aljona Kurbatova,
Head of the Infectious Diseases and Drug Abuse Department

CASES OF DRUG-RELATED DEATHS						
2011	2010	2009	2008	2006	2005	2004
123	101	133	67	68	57	98
Drug-related deaths per million: 135.7				Gender: majority male = 87.8% Mean age at time of death: 30.1 years		

LEGISLATION

Only medical doctors can legally prescribe naloxone. In the context of harm reduction services, the doctor must facilitate the training, after which the naloxone may be prescribed and dispensed.

PUBLIC HEALTH RESPONSES – CURRENT OVERDOSE PROGRAMMES

Estonia is in the process of establishing a naloxone distribution programme based on the Scottish model. It is centrally funded and is a very new scheme which required several years of planning and negotiation.

The programme was first made available in Tallinn from September 2013. Since January 2014 the programme has been available in two locations in Tallinn, also in Jõhvi (in one location), Kohtla-Järve (in two locations) and Narva (in one location). These are the areas most affected by injecting drug use and HIV.

“ The model is largely based on the Scottish experience although obviously from a much more resource-limited setting... It is similar in that it also receives governmental funding. ”

Prior to this, specific responses to preventing drug-related deaths were uncommon, although information on overdose risk reduction was available through low-threshold centres and outreach work to a limited extent. Information, education and communication (IEC) materials are now available on prevention of acute drug-related deaths and managing drug-related emergencies for family and friends.

Aljona Kurbatova,
Head of the Infectious Diseases and Drug Abuse Department

With regard to the new naloxone distribution programme, the target for 2013 was to distribute 500 naloxone kits in the community, although only 113 kits were actually dispensed. It is anticipated that this will increase, as more organizations have now been included in the programme, and the stock available for 2014 is 1300 kits.

Three doctors trained service users for approximately one hour and dispensed naloxone to them, with repeat dispensing readily available. The training is valid for three years and covers how to identify an overdose, first aid, CPR and calling an ambulance. The trainers can adapt the training and may shorten it to half an hour, depending on the needs and expectations of the service user. The training may also be longer for relatives and carers, as they may require additional knowledge.

Owing to a lack of familiarity with naloxone distribution among stakeholders, and the fact that only medical doctors can prescribe naloxone, the current model (based on that of Scotland) was adopted to enable confidence in the programme. The intention is to eventually allow nurses and, ultimately, non-medical staff to be involved in the training and distribution.

The Estonian government started funding NSPs in 2000, within the framework of the National HIV/AIDS Prevention Programme, although NSP provision was extremely limited and almost non-existent. In 2003 this was significantly scaled up as a result of Global Fund funding. In 2004, additional EU 'Phare Programme' funding enabled several new low-threshold centres to be established, and harm reduction measures were specifically mentioned in the National Strategy for the Prevention of Drug Dependency (2004–2012).

Consequently, the coverage and quality of NSPs has improved over the years. All these initiatives were integrated with the national strategy and implemented by the National Institute for Health Development under the Ministry of Social Affairs. Standards of care for funded NSP programmes stipulate that counselling on overdose prevention has to be included, and training has been provided to staff, although these interventions are not structured or systematically assessed. Services report such activity, but it is very varied, and it is unclear as to what level of

intervention is offered.

More than 2.2 million syringes were distributed in 2012 through a total of 37 syringe exchange sites (14 stationary and 23 outreach programmes). Almost all NSPs use peers to reach at-risk groups within an outreach framework, and this experience can easily be replicated and enhanced to involve these and other peers in future naloxone distribution, although the potential for peer involvement is limited at the present time. Some former drug users work in harm reduction services, but generally there is no community representation.

Methadone was officially introduced in 2001. While there has also been a modest increase in the coverage of methadone maintenance treatment in recent years, treatment capacities still appear unable to meet the growing demand. Clearly, the provision of OST assists in alleviating some risks of overdose, although methadone may also be implicated in some drug-related deaths.

Treatment is provided by both larger hospitals and smaller specialized healthcare clinics, with an increase in psychosocial services being offered by NGOs as well. These organizations are in a prime position to liaise with prison authorities to establish robust systems for throughcare and, at the very least, signposting to those service providers which are able to supply naloxone soon after release, as prisoners are particularly at risk – especially those planning to return to fentanyl use.

POPULATION

The first national general population survey on drug use in Lithuania was carried out in 2004, the second one in 2008, and the third in 2012. The 2008 and 2012 surveys were carried out in line with EMCDDA guidelines, and was conducted among people aged 15–64.

Data from the European School Survey Project on Alcohol and Other Drugs (ESPAD, 2011) survey showed lifetime prevalence of heroin at 2%.

In 2010 a capture–recapture study (based on data from the Ministry of Health, Ministry of Justice and Ministry of the Interior) was implemented to estimate the number of ‘problem drug users’ between 2005 and 2007. According to the study, in 2007 there were around 5458 problem drugs users (more than 90% of them being opiate users), representing 2.4 per 1000 population aged 15–64. Unfortunately, more up-to-date data are unavailable.

As of 1 January 2012 there were 19 healthcare institutions, in 13 municipalities, providing OST. In 2011, service providers reported approximately 5890 individuals with a drug dependency, of which 251 were new treatment clients. In 2011, 798 people received methadone – about 26% of new treatment clients were over the age of 35, while 24% were under 25. With regard to gender distribution, 80.9% of new treatment clients were male, and 19.1% were female.

In 2012 there were 513 people reported to be receiving OST. While methadone maintenance is continued for clients in police custody, it is discontinued if a client is given a prison sentence, since OST is not available in Lithuanian prisons.

OVERDOSE EPIDEMIOLOGY

Since 2010, data on drug-related deaths have been submitted by the General Mortality Register of the Institute of Hygiene. Drug-related deaths, in this instance, are defined as those lethal cases where the direct cause of death recorded on the death certificate is the use of narcotic and psychotropic substances.

The data from the registry are compliant with drug-related deaths standards, a standard protocol for extracting data on drug-related deaths from registers in the EU Member States, which includes acute deaths directly related to drug consumption or overdoses.

From the data available, it is not possible to estimate the number of opiate users at risk of overdose, and clearly OST can be a protective factor against overdose. While some deaths may occur in treatment, Lithuania operates a system of daily supervised consumption.

In 2011, Lithuanian healthcare institutions recorded 94 cases of non-fatal overdose/poisoning (opium = 53 cases; heroin = 41 cases), and these figures are similar to the number of cases in the previous four years. These data are provided by the State Patients’ Fund under the Ministry

of Health, although they conflict with the data below.

In 2011 some 45 direct drug-related deaths were recorded, which indicates a decreasing trend since 2007, when 72 drug-related death cases were registered. With regard to distribution by age and gender, the majority were male (82.2%), and the mean age at death was 33.4 years. No data are available regarding the ethnicity of people who died from overdose.

AGE GROUP	2007	2008	2009	2010	2011	CASES OF DRUG-RELATED DEATH
Under 15	0	0	0	1	0	<p>Source: General Mortality Register of the Institute of Hygiene from 2010</p> <p>Source: Until 2010, Department of Statistics under the Government of the Republic of Lithuania</p> <p>Toxicological analyses were reported for 97.8% of drug-related deaths in 2011. Opioids were the primary substances involved in 54.5% of drug-related deaths with known toxicology results, while 40.9% of deaths were due to mixed or unknown substances.</p> <p>Gender: majority male = 82.2% Mean age at death: 33.4 years Drug-related deaths per million: 20.9</p>
15-19	3	1	0	0	1	
20-24	12	10	6	12	6	
25-29	25	22	24	9	14	
30-34	20	6	16	10	10	
35-39	4	11	10	11	6	
39 and over	8	10	12	8	8	
TOTAL	72	60	68	51	45	

LEGISLATION

Naloxone is only available for use by medical personnel and emergency services.

PUBLIC HEALTH RESPONSES – CURRENT OVERDOSE PROGRAMMES

In 1997 the Vilnius Centre for Dependence Diseases, in collaboration with the Open Society Foundation in Lithuania, was the first organization to commence low-threshold programmes for people who inject drugs. A special decree of the Ministry of Health adopted in 2006 allowed for an expansion of programmes and also set the minimum criteria for services. In 2011, nine low-threshold units operated in seven cities, funded through local budgets. The number of service points dropped from 11 to 9 during 2010–2011 due to financial constraints.

In the Report on the Current State of Play of the 2003 Council Recommendation on the Prevention and Reduction of Health-Related Harm, associated with Drug Dependence in the EU and Candidate Countries it is stated that, with regard to the reduction of drug-related deaths, the dissemination of IEC materials is the predominant response strategy (Busch, Grabenhofer-Eggerth et al., 2013). These information materials are mainly distributed via low-threshold agencies and NSPs (and also three mobile NSPs) in Lithuania.

The aforementioned report states that, while also common in specialized drug treatment centres and detoxification services, risk education and overdose response training exists in

nearly all relevant cities/towns, with information materials on overdose available for police and prison staff, family and friends, and nightclub staff. However, this description contradicts the opinion offered during interview, that there are no formal overdose prevention programmes and interventions in Lithuania.

Indeed, there are no current plans to introduce naloxone distribution, although comprehensive OST programmes do exist and overdose rates are considered to be very low – i.e. 45 cases in 2011 and with a declining trend since 2007. However, the scale of the problem should not discourage policymakers and national stakeholders from taking a proactive approach in reducing drug-related deaths. One death is one too many – especially when overdose is potentially preventable.

It is purported that the low overdose rate may be due to the widespread supervised consumption of methadone, although it is also quite likely to reflect some under-reporting as well. With a number of deaths being recorded as of ‘unknown cause’ or an insufficiently specified cause such as respiratory failure, some of these deaths are likely to have been caused by opioid overdoses.

OPPORTUNITIES FOR INTRODUCTION OF (COMMUNITY) OVERDOSE PREVENTION/NALOXONE PROGRAMMES

ESTONIA

Since a naloxone programme has been underway since 2013, it is hoped that this programme will be scaled up to enable more people to be able to deliver training and dispense naloxone – especially peers who are already involved in outreach and NSP provision.

Realistically, the potential for peer involvement in the programme is limited at the present, although some former drug users work in harm reduction services.

Due to the lack of familiarity with naloxone distribution among stakeholders, the current programme based on the Scottish model will have to be evaluated to enable increased confidence in, and development of, the programme. Scotland is in the process of evaluating its national overdose programme, and there may well be lessons to be learned from this, once it has been published.

LITHUANIA

There are no plans to introduce a naloxone distribution programme, and opioid overdose is not considered to be a problem in Lithuania. Indeed, data on drug-related deaths show a decreasing trend. The dissemination of IEC materials is the predominant response strategy for reducing deaths in Lithuania, alongside delivery of comprehensive OST services. IEC materials are distributed at low-threshold agencies, NSPs, specialized drug treatment and detoxification centres.

One report asserts that risk education and overdose response training is available in nearly all relevant cities and towns, with information materials on overdose available for police, prison staff, family, friends and nightclub staff.

Given austerity measures and the fact that there is no political will to roll out naloxone distribution, it is unlikely to happen soon. The existence of widespread OST programmes which all supervise consumption of methadone is suggested to be one of the main reasons why overdose rates are low. However, it has also been implied that there is some under-reporting of drug-related deaths, and until data collection is improved, evidence is weak and will not favourably support the development of a naloxone programme.

“ There are no plans for naloxone distribution, and overdose education is not routine within services. We don't see a lot of overdoses – maybe there are more overdoses, but perhaps they are not registered as such. Methadone access is good, and it is well supervised. ”

Dr. Emilis Subata,
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CONCLUSIONS AND RECOMMENDATIONS

There are both limitations and opportunities for the two focus countries, Estonia and Lithuania. They both have distinct systems and trends, while the comparative countries also have markedly different levels of overdose prevention and management programming, with Scotland having the most developed, nationwide programme. It is still, relatively, early days, and Scotland is about to conduct a thorough evaluation of its national programme. Once published, it will be necessary to review this document to determine whether there are lessons to be learned in developing subsequent European programmes.

To influence national policy, it is important to provide a strong evidence base to support the development of comprehensive programmes. Equally, effective systems to enable robust data collection, monitoring and evaluation should be established, alongside common (European) standards, mutually agreed definitions and consistently used criteria for identifying drug-related deaths and, specifically, opioid-related deaths.

This should also include information systems which accurately collect and collate overdose-related calls, ambulance attendances and emergency services interventions so as to identify both fatal and non-fatal overdoses, which can then be used to inform local service planning processes. Until data limitations and discrepancies have been addressed, it is not possible to accurately reflect overdose epidemiology, nor compare drug-related deaths and overdose programmes in each country.

Equally, it is essential to improve the quality of existing responses to overdose. In the absence of naloxone programmes, all people who might witness an overdose must be urged to call emergency medical services immediately. Many people fail to do so because of various fears and legitimate concerns. Police forces and ambulance services should regularly review their policy of having a police presence at overdose scenes. Such reviews should acknowledge the evidence about the negative effect that fear of prosecution has on people's decision-making regarding calling for an ambulance, and steps need to be taken to both understand and resolve this issue. This means open discussion of such anxieties, inter-agency partnerships and local agreements on best practice in the primary interest of public health.

It is worth noting that, when calling emergency services, it is not necessary to disclose that it is a suspected drug overdose; stating that somebody has collapsed and is not breathing should suffice in the first instance, unless it is known that ambulance services do not routinely carry naloxone.

Best et al. (2001) recommend: "if a heroin user witnesses an overdose, they should be encouraged to immediately summon emergency services in the knowledge that, only in exceptional circumstances would the police be called to the scene and then make an arrest." A barrier to this, however, is that "reassurance is contingent on local protocols being worked out." Therefore, it is important to ensure that work is undertaken with all the emergency services to agree satisfactory procedures and practice.

Information should be made available to people who use drugs and their family members

regarding the current policy on police attendance at overdose events and the positive outcomes that this can achieve. Drug treatment services have a key role in providing clear factual information on such policy to help address and alleviate these relevant concerns.

People admitted to hospital following an opioid overdose should be routinely provided with IEC materials on overdose prevention, alongside details of local drug treatment and harm reduction services. Ambulance staff should also carry information about overdose management and contact details of local drug services. As a matter of course, this information should be distributed to people who overdose and to any witnesses at the scene.

Equally, drug treatment services should be able to provide a rapid response to those seeking support following an overdose incident. This may range from support and advice to prioritized engagement with structured treatment programmes and access to OST.

It is also vital to improve assessment of needs, particularly in relation to physical and mental health. Long-term opioid users should be offered regular medical examinations and liver function tests, since liver damage (along with some HIV, Hepatitis C and other medications) can decrease the efficient metabolism of drugs, thereby putting the individual at increased risk of overdose. In addition to this, standardized screening for harmful or dependent drinkers should form part of the review process for people in treatment programmes.

Structured suicide-risk assessments should also be conducted to identify suicidal ideation and moderate to severe depression, so as to provide more effective treatment interventions for this high-risk group. The care of people with co-morbidity issues must be coordinated to include all relevant services, and efforts must be made to ensure that any medication provided at any one time does not exceed the patient's therapeutic requirement or affect metabolism.

Drug treatment providers and pharmacists must be vigilant and safeguard against other 'depressant' drugs being prescribed on top of OST; it should also be ensured that any unused medications are returned to the pharmacy for disposal.

OST programmes should seek to reduce the number of people they discharge due to ongoing illicit drug use, as this predisposes the individual to a significant risk of overdose. Increased doses of OST may counter such additional drug use, and it should be ensured that people are not receiving sub-therapeutic doses (i.e. below 65 mls/mgs of methadone). If people are discharged, following alternatives being explored, then opportunities to re-engage them with treatment must be offered regularly.

All those working in drug treatment and harm reduction services (including reception staff) should receive regularly updated overdose information, guidance and training to enable improved cascading of information to people who use drugs. Similarly, overdose awareness training should be made available to all police, ambulance staff and clinical staff working in primary care and hospitals; this should cover the prevention and management of overdose, as well as the principles of harm reduction.

Consideration should be given to establishing/involving peer training networks to deliver some aspects of overdose prevention training. Action should be taken at national and local levels to ensure that information about the prevention and management of drug overdose is made available to people who use drugs and their families. Health and social care services should recognize the psychological impact of witnessing or experiencing an overdose; appropriate support and counselling should be offered in this case. The above conclusions and recommendations can be summarized as per the text box below.

“ A review by Rome et al. (2008) suggested several basic recommendations:

1. Improve the quality of existing responses to overdose incidents (police and ambulance).
2. Improve the assessment of needs.
3. Improve and extend current care provision for people who use drugs.
4. Provide information and training for emergency service staff.
5. Provide information and training for people who use drugs and their significant others.

Information and training for people who use drugs and their significant others. ”

It is relatively straightforward to make recommendations that can potentially prevent overdoses. However, it is clear that there are many barriers to implementing overdose prevention and management programmes which affect several professional levels and have an impact on different people – first and foremost, people who use drugs; second, witnesses (i.e. peers, partners, families and/or others); third, service providers; and fourth, national policymakers.

Without understanding the dynamics of these differently affected groups, the impact of any recommendations is likely to be limited, and while drug use should never be seen in isolation of other factors, nor should the risk of overdose.

Thus, it is also necessary to address prevailing stigma and discrimination. The attitudes of professionals, and how organizations respond to people who use drugs and overdose situations, is of critical importance in terms of enabling access to and engagement with services. Effort is thus needed to integrate the activities of such groups so that they can collaboratively support the roll-out of national overdose prevention and management programmes.

There are many other obstacles to the implementation and scale-up of effective overdose responses (and naloxone provision). These include laws limiting management and transport of naloxone by non-medical personnel; delays in emergency responses for overdose situations; and shortages of naloxone in emergency units. These issues need to be overcome at a national level, and as a matter of urgency.

There is a pressing need for high-level advocacy around scaling up the distribution of naloxone beyond medical services to harm reduction programmes, outreach workers, pharmacies, homeless shelters/hostels, people who use drugs, their families and communities. A simplified means of administering naloxone, such as pre-filled syringes or intranasal sprays, can improve confidence and may offer opportunities for those less familiar with injection drug use. However, these administration methods are more expensive, and this, in itself, may present another barrier for countries with limited resources.

The EMCDDA Preventing Overdose Report (2012) is a valuable resource and draws attention to risk factors, protective factors and responses, which can be categorized into three levels: individuals, observers and organizational. Rome et al. (2008) highlight a ‘cycle of overdose management’ which may be useful for training purposes and could guide the development of policy and practice.

SUMMARY OF INDIVIDUAL ROLES AND RESPONSIBILITIES

- **National stakeholders:** The willingness to work with people at all levels and involve peers – i.e. people who use drugs – in the planning, implementation and evaluation of services is crucial. Advocacy work to ensure that this can occur is also vital.

Both Scotland and Denmark exhibit such an approach.

- **Drugs services/workers:** They should, at the very least, aim to increase knowledge regarding overdose prevention and management through brief interventions training, and by taking a proactive approach to dissemination of IEC materials, some of which could be produced by peers.

Protocols on overdose prevention and management should be available in all treatment and harm reduction services, as per the Catalanian model.

- **People who use/inject drugs:** The communities who are affected themselves, potentially, have most knowledge and can increase access to vulnerable populations who may be otherwise hard to reach. As such, peer involvement in planning, implementation and evaluation must actively be sought *as per the Danish (and Scottish) models.*

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