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'GET UP, STAND UP'

Giving people the means to respond to opioid overdose

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THE SALVATION ARMY crisis services

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The Salvation Army Crisis Services respectfully acknowledge the Yalukit Willam clan of the Boon Wurrung. We pay our respect to their Elders, both past and present. We acknowledge and uphold their continuing relationship to this land. We acknowledge the traditional Aboriginal custodians of country throughout Victoria and respect the ongoing living culture of Aboriginal people.

AIMS & OBJECTIVES

This report was written as an evaluation of the Take Home Naloxone (THN) program at Access Health in St Kilda, Victoria. Access Health is a primary health service, managed by The Salvation Army Crisis Services located in the adjoining building in Grey St, St Kilda. The THN program – established in conjunction with Harm Reduction Victoria (HRV) –was the first if its kind in the state, to facilitate the distribution of a (then) Schedule 4 drug to opioid users and their peers. However, the early success of the model was soon replicated at a number of further community and primary health care services within inner-urban Melbourne. The expansion of peer distribution complemented a State Government funded initiative, the Community Overdose Prevention and Education program (known as COPE), which built on a Government commitment to increase community access to naloxone. Naloxone is an antidote to heroin overdoses, insofar as it rapidly revives the victims of an opioid overdose. The possession and use of naloxone had largely been confined to medical professionals – such as paramedics and Emergency Department medics called to attend to a case of overdose.

This evaluation was primarily conducted during the first twelve months of the program. Verbal briefings on the iterative findings from the evaluation were used by the staff team to improve elements of the program design over time.

AN OVERVIEW OF NALOXONE
- what is it?

Naloxone is a pure opioid-antagonist and is used to rapidly reverse the effects of opioid overdose. The drug works by displacing opioids at the brainstem receptors, rapidly reversing their effects (respiratory depression, sedation and low blood pressure) and has been widely used for decades. Until recently, Naloxone was classified as a Schedule 4 drug; leading to restricted access and tightly regulated use. However, naloxone is one of the rare drugs to have few if any unintended effects. It is non-addictive, has no intoxication potential and therefore no potential for abuse (Topp, 2011). In fact it has no effect on the body if there are no opioids present. If opioids are present, however, naloxone clearly has life-saving properties. While a large dose of naloxone can cause withdrawal in the dependent opioid user, 4 these affects are likely to be as short-lived as the drug's half-life of 30-90 minutes (The half-life is the time taken for the drug to lose half of its pharmacological effects on the body). Most opioid analgesics have a considerably longer half-life than naloxone, which may necessitate administration of a second dose if the overdose victim relapses into unconsciousness. Morphine for example, which heroin reverts to once injected, has a half-life of 2-3 hours (Lenton & Hargreaves 2000).[1]

As a Schedule 4 medicine, naloxone could not be legally administered by a layperson, but only by the person named in the prescription. There has been a reluctance on the part of general practitioners to prescribe naloxone to people at risk of overdosing, or to family members of those at risk. Instead, access and administration of naloxone has typically been restricted to medical personnel (whether paramedics called to attend at incidents of overdoses or doctors responding to an emergency admission in a case of overdose) (Penington Institute, 2015). This greatly limited the efficacy of this life saving response to opioid overdose.

The reasons outlined by the Australian Government's Therapeutic
Goods Administration (TGA) decision included the following:

- Naloxone is a well-tolerated life-saving medicine with minimal side effects. The benefits outweigh the risks;
- Benefits of rescheduling naloxone for reversal of opioid overdose to Schedule 3 include that products would be supplied labeled, with full and clear instructions for use, understandable by consumers. People who need naloxone would be able to obtain it more easily, which is likely to decrease the proportion of (deliberate or accidental, usually illicitly obtained) opioid overdoses that result in death. Increased accessibility would also potentially reduce morbidity due to opioid overdose, such as hypoxic brain damage.

1 The relatively short half-life of naloxone (approximately 30 to 90 minutes) compared to that of opioids means close attention must be paid to an individual revived after opioid overdose to ensure an ability to respond if they relapse into unconsciousness. For most, however, the period during which the naloxone is active is sufficient time for the central nervous system to return to normal function.

In response to continued pressure and advocacy from community services engaged with opioid users, and from researchers engaged with these same services, October 2015, the Advisory Committee on Medicines Scheduling (ACMS) acted in October 2015 to recommend an interim decision for dual scheduling of naloxone to allow its sale without prescription from pharmacies (for the purpose of reversing opioid overdose).

The interim decision was subsequently approved on 19 November 2015, and the Poisons Standard was amended to include a new schedule 3 listing for the 400-microgram mini-jet dispenser (a pre-filled syringe preparation). The new Schedule 3 implementation took effect on 1 February 2016. This allowed the sale of naloxone over-the-counter at pharmacies and provided drug users, and their families and peers, to bypass the need for an appointment with a GP to receive a prescription. However, it has also had an impact on the price of naloxone, with its sale as a Schedule 3 drug potentially making its cost prohibitive to some. Medications (with the exception of some asthma medications) must be provided on prescription to be subsidised under the PBS. The DPNQ (Dispense Price for Max Quantity) for naloxone was $99.88[2] if purchased over the counter. This is equivalent to approximately $19.98 per mini-jet (although this can vary at the pharmacist's discretion). In comparison, as a Schedule 4 drug, naloxone costs $37.70 (or $6.10 for concession holders) for 5 minijets.

There is a good argument to be made for the Commonwealth to subsidise the costs of naloxone in a model similar to that used for providing methadone or buprenorphine as opioid maintenance treatment. In this case, the Commonwealth pays the full costs of the opioid medication and the client pays the cost of dispensing fees. As a Schedule 3 medicine there would be no dispensing fees associated with naloxone sold over-the-counter. This would ensure there is not the similar disincentive that dispensing fees have on retention in the aforementioned treatment.[3] The provision of naloxone in this way is likely to save lives and reduce the costs and trauma associated with the ongoing health related effects of overdose. Saving lives provides intangible benefits of a nature that well outweighs the costs of such an investment.

The rescheduling of naloxone has been of great benefit in increasing accessibility to naloxone (despite its currently potentially prohibitive cost as an over-the-counter product particularly for vulnerable opioid users living on government income support). However, it has provided community services involved in the distribution of naloxone to drug users and peers with an alternative means of accessing the drug. In May 2016, a pharmacist at Ballarat Community Health received approval from the Victorian Pharmacy Authority to supply naloxone directly from the service's Needle & Syringe Program (NSP) (i.e. outside of a pharmacy) and free-of-charge to consumers (Molloy 2016). This is indicative of the manner in which the community health sector – and particularly services operating within a harm reduction framework – has acted on the government's COPE led strategy to facilitate access to naloxone to broaden its distribution beyond its once limited reach.

It is important to recognise that the take home naloxone (THN) program initiated at The Salvation Army's Access Health began well before rescheduling of the drug. Indeed, calls for such change had been made for well over a decade (e.g. Strang et al. 1996; Darke & Hall 1997). The willingness of The Salvation Army Crisis Services to adopt a strategy, until then untried in the State of Victoria, was indicative of an innovative, client-led approach to the continued evolution of its suite of services. In fact it was the fatal overdoses of individuals associated with Access Health, community members and clients, that focused those involved on the decision to act to stop more preventable deaths. This report reflects on the efficacy or otherwise of the courageous decision to step into what was, at that time, the unknown space that was peer education and distribution of naloxone.

2 All prices cited were correct at the time of writing. The cost of PBS subsidised pharmaceuticals (the 'co-payment' paid by the customer) is adjusted in line with indexation at the start of each calendar year (see: http://www.pbs.gov.au/info/about-the-pbs for further information about the PBS).

3 This disincentive has been written about in depth elsewhere (see Rowe, J., 2008 A Raw Deal: Impact on the health of consumers relative to the cost of pharmacotherapy, The Salvation Army Crisis Services).

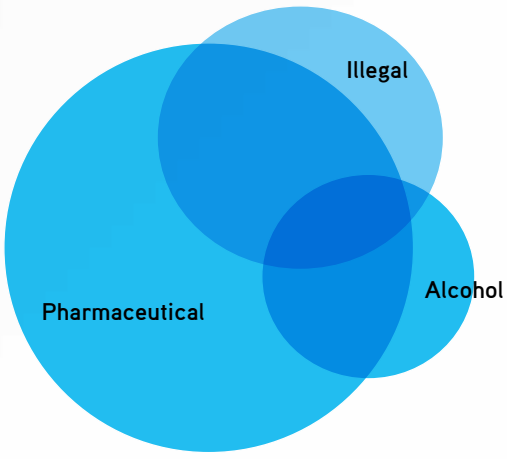
THE REALITY OF OVERDOSE FOR INJECTING DRUG USERS

Overdose is the single greatest cause of mortality and morbidity associated with drug use (Green et al. 2008). Opioids and benzodiazepines are the primary cause of drug overdose deaths investigated by the Victoria Coroner, particularly when used together (Jamieson 2015). Opioids are central nervous system depressants and their use in multiple forms or in combination with other depressants such as benzodiazepines and alcohol greatly increases the risk of overdose. In a presentation at the International 'Medicine in Addiction' Conference in Melbourne in March 2015, Victorian State Coroner, Audrey Jamieson, drew attention to the increasing role of pharmaceutical drugs in fatal overdoses, noting that they were far more prevalent in overdose deaths than illegal drugs (Jamieson, 2015).

Coroner Jamieson drew upon forensic pathologists' investigation into the 384 deaths that were attributed to fatal drug overdoses in Victoria in 2014. These indicated that 82 per cent involved the consumption of pharmaceutical drugs compared to 42 per cent involving the use of illegal drugs (and 24% in which alcohol was a contributing factor) (Jamieson 2015). Benzodiazepines contributed to most deaths, with diazepam present in 164 deaths. Heroin was the next most prominent drug, involved in 125 deaths. The pharmaceutical opioid oxycodone was present in 46 deaths. Most notable in the context fatal drug overdose is Polydrug use (the consumption of different combinations of drugs). Some 40 per cent of deaths were due to a combination of prescribed and/or illegal drugs and/or alcohol as indicated by the following figure reproduced from the Corner's presentation.

The Coroner's presentation clearly has implications for the distribution of naloxone to drug users and their peers. Although not effective in reversing the effects of benzodiazepines or alcohol on the central nervous system, naloxone effectively reverses the effect of opioids, regardless of legal status, and, consequently, greatly reduces the risk of an overdose caused by Polydrug use.

Pharmaceutical -Illegal - Alcohol nexus



42% Pharmaceutical drugs only
20% Pharmaceutical and illegal drugs
14% Illegal drugs only
12% Alcohol only
5% Pharmaceutical drugs, illegal drugs and alcohol
1% Alcohol and illegal drugs

Figure 1: Reproduced from presentation by Magistrate Audrey Jamieson, Coroner, Victoria (21 March 2015)

Legally prescribed pharmaceutical opioids have become increasingly prominent in media reports about problematic drug use and the morbidity and mortality that results (e.g. Seeyle 2016; Jones et al. 2013). In the United States, the Centres for Disease Control and Prevention report that despite that being no discernible change in the nature of 'the amount' of pain reported by patients (Chang et al. 2014; Daubresse et al., 2013), the amount of pharmaceutical painkillers prescribed has quadrupled since 1999. Of 43,982 drug overdose deaths reported in 2013, 16,235 (37%) were associated with prescription opioid analgesics as compared to 8,527 (19%) associated with heroin (Wheeler et al. 2015). Although not yet on the scale seen in the US, the rapid rise in mortality and morbidity attributed to prescribed opioids has led to warnings from the likes of the Coroner's Office to exercise extreme caution when prescribing opioids (e.g. Department of Health 2014). The increased prescription and, invariably, the diversion of legally dispensed opioids has prompted some to consider the wider distribution of naloxone to address potential overdose throughout the broader community. While this subject is beyond the remit of this report, it illustrates that the implications of opioid overdose has shifted beyond the injecting opioid community and, as such, findings from this research may well be relevant beyond Access Health's target community.

This research was specifically undertaken to engage with the needs of those service users for whom Access Health was established. In its initial funding agreement with the Victoria Department of Health, these populations, although far from mutually exclusive, were identified as street-based drug users, street based sex workers, and the homeless and transient individuals within the City of Port Phillip. In a practical sense, any individual in need will not be turned away from Access Health. However, it is a service established for those for whom mainstream health services are inaccessible or, at the least, challenging environments.

Overdose is reality of life amongst injecting opioid users, either through the personal experience of overdosing, witnessing an overdose or losing a friend or relative to overdose. The National Drug and Alcohol Research Centre maintain the Illicit Drug Reporting System (IDRS) to monitor and report on the use of illegal drugs by people who inject drugs (PWID). In the 2014 Illicit Drug Reporting System (IDRS) Report, 40 per cent of the 898 PWID surveyed reporting having overdosed on heroin in their lifetime (15% in the past year) (Stafford & Burns 2015, 96). Although there has been a dramatic increase in the use of pharmaceutical opioids, heroin remains the drug of choice for PWID. Of the 898 survey respondents, 50 per cent nominated heroin as their drug of choice (a figure that rose to 65% if considering the 150 participants recruited in Victoria). Further, 41 per cent of the national sample (62% of the Victorian sample) reported heroin as the drug 'most often injected in the last month', followed by methamphetamine and morphine. The increasing prevalence and use of illegally diverted pharmaceutical opioids (e.g. Whitelaw, 2015; Roxburgh et al. 2011, Duncan 2010) was reflected in the numbers of persons who reported using morphine (37%) and oxycodone (35%) in the six months prior to interview (Stafford and Burns 2015, 12). The use of drugs other than one's drug of preference was reportedly related to issues of availability (for 40% of participants) and price (19%). Regardless of the reasons, the opportunistic use of pharmaceutical opioids has led to a dramatic increase in prescribed opioid analgesics contributing to fatal overdose.

THE REALITY OF OVERDOSE FOR INJECTING DRUG USERS

A major consequence of criminalising drugs that have significant consumer demand is the inevitable presence of criminal elements that realise the opportunity – and profit – to be had by meeting this demand. The absence of the pricing and quality controls that regulate the licit drug market means that heavily adulterated drugs are sold to increase profits. Heroin, like any drug brought on the street, is of varying potency. Lack of knowledge as to the purity of the product is one of the key causes of heroin overdose. Victoria experienced unprecedented levels of heroin overdose from 1995-2001 when a 'glut' of heroin led to falling prices and rising levels of purity (see Van den Boogert & Davidoff 1999; VIFM 2006). As discussed previously, overdose is a result of opioids binding to those receptors in the brainstem that regulate breathing. If desensitised, the breathing mechanism is no longer triggered leading to respiratory failure and, ultimately, fatal overdose. The day-to-day variation in purity of street based heroin means that an individual can never be certain of the purity of the heroin they are injecting and, as such, is always at risk of overdose. A single batch of heroin with a markedly different purity to the average levels on the street can lead to a spate of overdoses in a concentrated area over a relatively short period of time.

Past research suggests that a significant contributor to past cases of fatal overdose has been the reticence of drug users and peers to call for emergency ambulance attendance for fear of attracting police attention (e.g. Dietze et al. 2000). This was once a major factor in peers' perceived powerlessness in the face of an overdose. In 2000, research suggested that an ambulance was only called in approximately 10 per cent of overdose cases (Lenton & Hargreaves 2000). The fact that witnesses are, more often than not, also PWID engaged in a criminal activity has been acknowledged as a factor that has compromised the decision to call medical authorities in the past. It should be acknowledged that the incidence of such cases has declined significantly following the adoption of the policy of harm minimisation throughout Australia. In Victoria, police recognise overdose as a medical emergency and no longer attend when an ambulance is called. As stated in the Victoria Police Manual:

Removing the fear of prosecution may encourage people present at overdoses to call for an ambulance without delay thereby reducing the potential for an overdose death or serious injury (Victoria Police Manual 4.1.2).

However, despite official Victoria Police policy to minimise the presence of law enforcement authorities at overdoses (as a direct response to reports of their potential presence dissuading peers from calling emergency responders), drug users and drug outreach workers have continued to observe police attendance at incidents of overdose (Dwyer et al 2013). Fear of police attendance continues to dissuade some peers from calling emergency responders in the case of an overdose – particularly if unaware of police procedures to only attend overdoses if requested (Topp, 2011).

BYSTANDERS AND PEERS AT AN OVERDOSE

Until the current prescription and dispensing of naloxone to peers, the response on the part of any witnesses to an overdose has largely been restricted to calling emergency services (unless trained in first aid and emergency breathing procedures such as CPR). The relatively short time it may take for an ambulance to arrive – in addition to the time taken by witnesses in deciding whether or not to call for outside intervention – may be long enough for an overdose victim to suffer irreversible brain damage. In contrast, if equipped with naloxone and suitable training, there is ample time for peers to respond. Fatality from opioid overdose is rarely instantaneous. In a majority of cases, death occurs in a window of 1-3 hours (instant fatality occurring in approximately 15% of cases) (Lenton and Hargreaves 2000; Sporer 2003; Green et al. 2008). There is clearly a significant window in which witnesses can respond to an overdose – a life-saving intervention. This is underscored by research findings that the greater majority of overdoses occur in the presence of others, whether other drug users or others in the immediate vicinity. Topp (2011, 24) observed that 'at least 60 per cent of fatal overdoses occur in a home, with somebody else present and more than an hour after injection' (Topp 2011, 24). Further, Darke et al (1996) found that those PWID who participated in their research indicated a willingness to intervene to prevent an overdose, even if not closely connected to the victim. Prior to the distribution of naloxone, however, peers (or other witnesses) have not had the means by which to intervene beyond calling for the attendance of emergency services.

BYSTANDERS AND PEERS AT AN OVERDOSE

There are further benefits worthy of discussion in respect of 'empowering' drug users in an overdue departure from the familiar caricature of the irresponsible and dependent (on both drugs and 'goodwill') drug user. While the term 'empower' is not used to imply that PWIDs lack agency or ability to render assistance, they have been effectively treated as such by policy makers despite their active adoption of harm reduction policy practices. The embrace of Needle and Syringe Programs has been of benefit to PWIDs. However, the success of this measure in preventing the spread of HIV among this population and to the broader community has only succeeded because PWIDs adopted safer injecting practices as recommended by public health authorities (Madden 2014). Similar to the danger posed by blood-borne viruses, overdose is an ever-present threat to users of drugs sold on a black market without the quality controls that would allow for consistency of purity and dose. This is a risk known to those for whom the pleasure and / or therapeutic benefits of heroin and / or other opioid use are perceived to outweigh the attendant risks of overdose. In contrast to a past reliance on 'official' responders to 'save' an overdose victim, the opioid user and their peers are now able to respond to these adverse effects directly and immediately, reviving the victim using Naloxone before seeking further assistance as needed. This significant change in drug users' agency to intervene was evident in the interviews for this research and shall be discussed in detail in the participants' experiences section of this report.

A CALL FOR NALOXONE

Given the time available for potential witnesses to intervene in the case of opioid overdose, researchers had been calling for the training of injecting opioid users and their peers in overdose recognition and naloxone administration along with its distribution to the same since from the mid-1990s (see Strang et al 1996; Darke & Hall 1997). A 1996 editorial in the British Medical Journal, released at a time when heroin use – and associated overdose - began escalating dramatically across south-eastern Australia, noted that while overdose was an 'occupational risk' of heroin use, 'one of the major contributors to a fatal outcome is the inadequacy of heroin users' responses to the overdoses of their peers' (Strang et al. 1996, 1435). The provision of naloxone to drug users as part of a comprehensive overdose response was seen as a pragmatic response to this perceived inadequacy. Publicity and, consequently, public concern surrounding heroin overdose has declined with the availability of the drugs. The priority once accorded the issue has been further diminished by constant, often exaggerated reports of the threat posed to the wellbeing of Victoria by crystal methamphetamine ('ice') (see Fitzgerald 2015). However, a continued need for naloxone distribution is underscored by the fact that opioid overdose remains the primary cause of death related to illicit drug use. Prof. Simon Lenton of the National Drug Research Institute noted in an interview:

> The heroin shortage hit at the end of 2000, and all the momentum for moving forward on naloxone distribution to peers and others fell away. The focus has been on amphetamines, but latest figures show that on average one Australian dies of a heroin overdose each day … We should not be waiting for the next heroin glut and spike in overdoses to generate the momentum to roll out this safe and effective intervention (ANEX 2010, 1).

Although advocates for wider naloxone distribution initially called for a trial of naloxone distribution to peer networks, clear international evidence of success in programs across the United States and the United Kingdom have rendered such a cautious approach unnecessary. A US comparative study of community-based naloxone distribution indicated that providing training and naloxone to drug users, their families and friends had contributed directly to a reported 10,171 overdose reversals (Wheeler et al. 2012). In the decade since 2000, state sanctioned distribution of naloxone commenced in nations including Canada, Germany, Russia, Spain, Norway, China, Vietnam, the UK and, at the time of writing, at least 17 states in the US (Topp 2011). This has provided a substantial body of international evidence clearly demonstrating the value of naloxone when peers are present at a potentially fatal overdose (for e.g. Bennett & Holloway 2012; Green et al. 2008; Maxwell et al. 2006). A 2008 survey of Melbourne PWID (Lenton et al. 2009) found that nine in 10 thought peer naloxone a 'good' or 'very good' idea and expressed a willingness to participate in training. On the basis of support among the prospective target population - as well as the positive evidence gained from evaluating international trials in peer distribution led Lenton and colleagues to argue that:

> [In light of the clear international evidence], a trial in this country is now unnecessary and Australian governments should take steps to increase access to naloxone. Wider distribution of naloxone as part of overdose prevention training should begin with known high-risk groups, namely those most at risk of overdose because of reduced tolerance … Careful monitoring and evaluation would be a prerequisite (Lenton, et al. 2009, p.584)

In December 2014, the World Health Organisation (WHO) issued its first ever Guidelines on the Community Management of Opioid Overdose and, in doing so, observed that improved access to naloxone could save many thousands of lives around the globe at minimal cost.

THE POLICY CONTEXT:
POLITICAL APPROVAL OF NALOXONE DISTRIBUTION

On 30 August 2013, one day prior to International Overdose Awareness Day, Mary Wooldridge, the then Victorian Minister for Mental Health and Community Services, announced the intention of the State Government to 'educate at-risk drug users, family, friends, and other potential non-medical [opioid] overdose witnesses about the benefits of naloxone and how to administer it in the event of an overdose' (Wooldridge 2013). The resulting policy implementation would become the COPE program. Implicit in the Minister's words are questions related to the distribution restrictions required by the then classification of naloxone as a Schedule 4 drug. At its heart, the Minister's announcement signalled an important evolution in drug policy in Victoria – and paved the way for the dual scheduling of naloxone.

The distribution of naloxone to drug users and their peers provided a rare example of government taking the opportunity to further incorporate the principles of harm reduction into a sustainable and sensible drug policy in Victoria. The decision of the Napthine-led Victorian State Government to support distribution amongst PWIDs and their peers was significant for Australia. Importantly, the policy reflected a move forward for Australian drug policy that – despite an initial and internationally acclaimed embrace of harm reduction when adopted as the underpinning principle of Australian drug policy in the late 1980s – has been better characterised by stagnation in the years since. The provision of naloxone marks a departure from the persistent reliance on ineffective and counterproductive criminalisation of 'illicit' drugs under the prohibitionist paradigm that defined Australian drug policy since inception.

To suggest that broader distribution of naloxone was overdue in Australia acknowledges the exasperation of those who advocated for wider access to the drug for many years (e.g. Lenton & Hargreaves 2000). Consequently, the Community Overdose Prevention and Education (COPE) project, as the government initiatives was named, represented a major shift in policy regarding heroin users. Injecting heroin users have long been constructed as 'junkies' – a derogative stereotype of an amoral and pathological existence that has little purpose but the procurement of one's next 'hit' (Keane 2002). Although the introduction of harm reduction policies have long sought to reframe illicit drug use as a health issue (as opposed to a criminal offence), drug users have continued to argue for greater inclusion in formulating and executing policy responses that have remained largely entrusted to professionals (e.g. Jurgens 2008). Until the distribution

of naloxone to drug users, witnesses to an opioid overdose have been compelled to rely upon emergency attendance by ambulance paramedics to revive the unconscious user. The witness, typically a peer, becomes a passive observer of the outcome – often directed to clear space around the overdose victim (who may be a close friend or relative) by the paramedics whose authority and professionalism provides them with 'ownership' of the situation.

In contrast to the above scenario, the Minister's press release forecast the intention to distribute naloxone to, amongst others, 'at-risk' drug users and their peers once trained in overdose recognition and the administration of naloxone. The COPE Program was to form a key part of Reducing the Drug and Alcohol Toll: the Victorian Government's drug and alcohol strategy (2013-2017) and the Penington Institute was delegated responsibility for the implementation of the program. According to the Centre for Research Excellence into Drug Use (CREIDU), COPE commenced in August 2014, almost a year after the relevant press release.

Although Access Health is formally integrated within the state-wide COPE project via membership of its reference group, this research does not address naloxone distribution within the COPE program. The COPE reference group operates under the auspices of the Penington Institute, as does the execution of the policy and its' evaluation. This research explores the effectiveness and sustainability of the Take Home Naloxone (THN) program initiated and trialled by Access Health. The training and support provided under the aegis of COPE has worked effectively to complement the THN program undertaken by Access Health in conjunction with Harm Reduction Victoria (HRV). To this end, the Penington Institute received COPE funding to develop training materials and hold seminars and workshops across Victoria. As opposed to a focus on drug users and peers, the COPE program aimed to raise awareness of naloxone among medical professionals, primary health care and community services who are in regular contact with opioid users. By drawing attention to the benefits of widespread naloxone distribution, the COPE program sought to embed naloxone use as a standard first aid response to opioid overdose. Further, the Penington Institute worked with the Victorian branch of the Pharmacists Guild of Australia to facilitate effective distribution of naloxone. In July 2015, for example, a broadcast by the Pharmaceutical Society of Australia was facilitated to draw members' attention to the fact that naloxone mini-jets did not come with needle tips and that suppliers needed to supply these separately (Penington Institute 2015b).

The Penington Institute is responsible for collecting data from the service and health providers (e.g. GPs and pharmacists) to assist the state government in assessing the reach of the COPE program and its impact on people at risk of overdose. In contrast, the research below is focused on the distribution of naloxone by Access Health and HRV in a model that was quickly adopted by other primary health care centres targeted towards the street-based and transient population whose opportunistic polydrug use has made them especially vulnerable to opioid overdose (Rowe 2003, Rowe 2006).

THE SERVICE SETTING
– ACCESS HEALTH

The Salvation Army Crisis Services has been operational in Grey Street, St Kilda since 1984. Since that time, Crisis Services have provided assistance to those in need of material, legal or emotional support. From the outset, Crisis Services adopted an approach of adapting to meet the needs of those who encounter obstacles that compromise their access to mainstream community services. In doing so, Crisis Services has expanded to incorporate, among other services, the Crisis Contact Centre (CCC), to provide information, advocacy and material assistance to those who are homeless and in crisis and the Needle and Syringe Program (NSP) was established in 1991, as the primary provider in the City of Port Phillip. The NSP is funded to provide injecting supplies, safe sex products and referral advice and salient information to injecting drug users. It is operational every day of the year and is accessible 24 hours a day. In 2003, TSA Crisis Services initiated a research plan to assess and document the health needs of injecting drug users using the NSP. This confirmed the vulnerability of a large population of transient and street-based PWID in the City of Port Phillip and a range of potentially serious health problems, many exacerbated by unstable and insecure accommodation. A feasibility study and the subsequent rationale, design and staffing of a proposed primary health service led to the opening of Access Health on 1 September 2004.

Access Health was established to provide an easily accessible primary health care response to those living on the 'margins' within the broader Port Phillip community. As noted in its initial mission statement:

The central aim of Access Health is to provide primary health care that enhances the health and wellbeing of street-based PWID and other vulnerable members of the community who have difficulty accessing appropriate health care via 'mainstream' services. To meet this aim, Access Health delivers services within a social health model.

As noted above, Access Health is open to any individual for whom mainstream health services are unaffordable or inaccessible. In 2013-14, there were 1,503 individual clients registered at Access Health, of who 486 had registered in the previous 12-months. These individuals accounted for 11,118 visits between them. Access Health is intended to serve as a first point of contact with the health system and is specifically located as closely as is possible to where the target clientele congregate. Given that injecting drug users are one of the key populations targeted by Access Health (along with people who are experiencing homelessness or street-based sex working populations – none of which are mutually exclusive but all of which are disproportionately represented in St. Kilda), the decision to establish the service adjacent

to the NSP was made to capitalise upon the patronage of the primary NSP in Port Phillip. In 2013-14, there were 45,737 contact visits at the NSP, underscoring the extent to which this service provides one of the few points through which injecting drug users can be reached for educative, research and health promotion purposes (The Salvation Army 2014).

By referring those in need of a primary health response directly to the adjoining facility, NSP staff are able to ensure clients take the first step in a process towards good (or better) health via a balanced system of treatment, preventive measures and educative health promotion. The distribution of naloxone fits in with each of these aspects of the primary health care response. The philosophical basis of primary health care incorporates a broader aim of addressing the social, political and economic determinants of health (Wass 2000). Indeed, the distribution of naloxone to some of the most marginalised members of the community represents a considered step towards addressing the potentially fatal consequences of policies that criminalise drugs such as heroin and inadvertently stimulate an unregulated criminal market in which the purity of heroin can vary dramatically and unexpectedly. Equipping heroin users and their peers to respond in the instance of a resulting overdose is reflective of a broader belief in the need to enable all people to achieve their full health potential. In establishing a facility attuned to primary health and its objectives, Access Health aligned itself with the 1986 Ottawa Charter for Health Promotion and the belief that:

> Health promotion is the process of enabling people to increase control over and improve their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and realise aspirations, to satisfy needs, and to change and cope with the environment. Health is, therefore, seen as a resource for everyday life, not as an objective of living. Health is a positive concept emphasising social and personal resources as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing (WHO 1986).

This entails a way of thinking about health and basic human needs to include the broader determinants that affect health and create need. It acknowledges the existence of widespread inequality and injustice – and that those who pay the heaviest price for inequitable social structures are often those with the least to give. The impact of poverty and desperation on mental and physical health has been well documented (e.g. Williams 2003; Wilkinson & Marmot 2003; Lynch & Davey Smith 2002; Baum, 2002). In this context, delivering services utilising Primary Health Care principles reflects an intention to reduce the inequities that contribute to poor health. It emphasises individual and community empowerment, engagement and participation – and the provision of naloxone, as noted briefly above, allows marginalised members of the community a direct role in their own survival and that of their peers (Kelleher & Murphy 2004).

ACCESS HEALTH STEPS
'OFF THE EDGE'

Access Health did not initiate peer distribution of naloxone as a nominated COPE site. Instead, it made a decision to begin distributing naloxone independently prior to the announcement of the government sponsored COPE initiative. The latter model identified early adopter sites and targeted training resources towards practitioners likely to see injecting opioid users during the course of general practice. This is in contrast to the manner in which Access Health has organised HRV to provide training in overdose recognition and naloxone administration to opioid users and peers. In making this distinction, we do not seek to diminish, in any way, the importance and innovation inherent in the state sanctioned COPE Project. Each model can complement the other and ensure the broader distribution of naloxone throughout the Victorian community. Just as the two models complemented each other at Access Health after the COPE program began raising awareness of naloxone and the resources for training community and health service personnel in its use.

That said, the implementation of the COPE model was hampered due to factors outside of the Penington Institute's control. The most significant and frustrating of these was a state-wide evaluation and restructure of the government funded (non-residential) drug and alcohol services, the unknown end result of which left other frontline services unable to commit to the COPE program. Concern about the levels of continued funding meant these services did not know what their ability would be to employ practitioners able to prescribe naloxone under the COPE model.[4] The frustration felt by staff at front-line services of dealing with PWID was compounded by the deep upset at the loss of people to overdose, particularly when potential means of preventing these outcomes was being supported at the highest levels of political office. Around this time at Access Health, the loss of three regular clients was keenly felt and focused thoughts on the need for immediate action. One case allegedly involved a first time injector, and all involved members of the local community and regular clients known to staff. Professor John Strang from the National Addiction Centre in London had first raised the notion of naloxone distribution amongst drug users and peers in Victoria when attending the International Harm Reduction Conference in Melbourne in 1993. Twenty years later, Prof Strang presented ongoing research on the validity of providing access to naloxone as a response to overdose at a Centre for Research Excellence in Injecting Drug Use (CREIDU) Colloquium entitled: 'Pre-provision of naloxone to prevent heroin overdose deaths: evidence, myths and UK experience'. Soon after staff from Access Health and the NSP attended the CREIDU colloquium, discussions with TSA Crisis Services management team culminated in the decision to initiate the THN program. In collaboration with HRV, Access Health began to facilitate training in overdose recognition and naloxone administration on site in August 2013. The COPE Program would not identify 'early adopter' sites until after Access Health and HRV had already committed to an ongoing training program. Indeed, Access Health was one of the COPE early adopter sites, the education materials and training opportunities for staff complementing the peer-led initiative with a comprehensive and professionally-informed overdose response strategy.

4 Personal communication, DHS harm reduction policy officer, 30 July 2015. 19 would not identify 'early adopter' sites until after Access Health and HRV had already committed to an ongoing training program. Indeed, Access Health was one of the COPE early adopter sites, the education materials and training opportunities for staff complementing the peer-led initiative with a comprehensive and professionally informed overdose response strategy.

THE ACCESS HEALTH MODEL
– TAKE HOME NALOXONE

Access Health in collaboration with HRV, via the Take Home Naloxone (THN) program, has delivered training in overdose recognition, naloxone administration and the fully funded prescription of naloxone via two pathways; either via workshop attendance or through a one-on-one education session on appointment with a nurse which later became aligned with the COPE project. This dual pathway model was designed to provide the greatest flexibility and allow access to as many clients as possible. The initial model for training was to run workshops delivered collaboratively with Harm Reduction Victoria (HRV), an NGO that works to advance the health, dignity and social justice of people who use drugs in Victoria. As an organisation with over a decade of experience in providing peer education with a focus on overdose prevention and response, HRV was eager to add naloxone distribution to the strategies already being offered within a peer framework by their dedicated Drug Overdose Prevention and Education (DOPE) worker. This worker conducts training in group workshops facilitated at and by Access Health. Workshops commenced in August 2013 and were initially held on a monthly basis until demand saw the frequency of workshops increased to twice monthly and, at time of writing, approximately two workshops every three months.

THE WORKSHOP PATH

The needle and syringe program at the adjoining Crisis Contact Centre has been the primary means through which monthly workshops have been publicised, either via the posters or word-of-mouth to clients known to be injecting opioid users (or peers of users). Clients identified by NSP staff as potential participants were informed of workshops at which the HRV peer worker led training in overdose recognition and response, incorporating the use of naloxone. Alternately, staff at Access Health aware of a client's drug use or other reasons for which they might benefit from engaging in overdose response training and naloxone distribution would brief individuals about the availability of places at upcoming workshops and, enrol them to participate. An incentive payment of $20 was also provided by HRV as a means of stimulating recruitment (which is consistent with all of their peer education sessions). Follow up calls on the day of the workshops sought to encourage full attendance. In the event of a registered participant failing to attend, opportunistic recruitment of clients attending at the NSP and / or Access Health ensured scheduled workshops went ahead as planned. Naloxone would be prescribed and dispensed free of charge to workshop participants by the GP at Access Health upon completion of workshops. Naloxone was provided as part of an overdose response kit that included the drug in the form of five mini-jet syringes, needles for the syringes, a mouth piece for providing safe CPR breathing, single needle disposal containers, alcohol swabs, an instruction card, and a drug information card and fit sticks sharps disposal. Those involved

THE ACCESS HEALTH MODEL
– TAKE HOME NALOXONE

in the process of establishing the THN program went through a clear and deliberative process in which staff responsible – across disciplines of medical health and health promotion – spent a considerable amount of time deliberating about the information to include and the contents of the overdose response kit.

Workshops began on August 31 2013 at Access Health and have since been facilitated by the Drug Overdose Prevention & Education (known as DOPE) worker from HRV. Over the course of approximately one hour, workshop participants pre-training knowledge of overdose and response protocols are assessed, myths and misinformed beliefs are discredited by emphasising the correct response, and the safest and most effective means of administering naloxone is taught; typically via an intramuscular injection in the thigh or upper arm. Although many long-term intravenous drug users have considerable experience injecting drugs into veins – including in often challenging conditions – the area in which the injection is administered is of some importance, with risks of nerve damage if injecting into the buttocks as just one example of potential complications from the injecting process. The existence of blood borne viruses (BBVs) adds a further potential complication in respect of intravenous administration.

The workshops provide participants with a fairly intense period of engagement in which information is provided in an interactive capacity in respect of overdose recognition, administering naloxone, and demonstrating rescue breathing on a dummy (with contact and potential transmission of bodily fluids prevented by use of a prophylactic mouth piece).

> That was one great thing about the workshop, having the [dummies used for demonstration and practice of CPR and rescue breathing technique] and being able to practice it, you know? If you see videos of it [it gives you some idea], but actually getting a chance to do it on one of the dolls and being shown how to do it and [being instructed in] general first aid was good. That was really great to know (Mel 24 February 2014).

At the same time that participants are receiving training, staff from Access Health take the prescriptions for the naloxone to the local pharmacy to be filled. Once dispensed, the naloxone is divided into small overdose response kits that resemble a slim pencil case. Workshop participants complete a pre- and post-workshop questionnaire about overdose scenarios to evaluate their understanding and retention of the material provided, and are provided the kits and payment for participating.

The administration of naloxone is just one part of the overdose response that participants are trained in. The length of time spent without the brain receiving oxygen can have permanent repercussions and the necessity of professional medical assessment is consequently emphasised. Likewise, the (comparatively) short half-life of naloxone compared to an opiate such as heroin means some individuals may need further attention until any opioids have been fully metabolised, particularly given the potential for (re)lapse into unconsciousness. Consequently, the importance of calling emergency medical assistance remains a part of the overall overdose response after acting to revive the overdose victim and restore the supply of oxygen to the brain.

NON-WORKSHOP ACCESS PATH – ONE-ON-ONE TRAINING WITH A NURSE OR DUTY/SOCIAL WORKER.

Group workshops are not the only means by which clients are to access naloxone through Access Health. There may be several reasons that injecting drug users are unwilling to attend group sessions. Concerns about the confidentiality of the sessions and / or a reluctance to divulge their injecting drug use to others may have been an obstacle to attending training in overdose recognition and response. If unable or unwilling to attend training workshops, clients could attend individual sessions with Access Health nursing staff or duty / social workers. RDNS Homeless Persons Program nurses based at Access Health are well versed in training injecting drug users in health promotion and harm reduction including improving injecting techniques and practising vein care and in this capacity, a confidential face-to-face training was an alternate means of making naloxone available to clients to be trained in overdose recognition and response. This option would also ensure clients could get access to naloxone immediately, rather than wait for a workshop date. This is an option that is taken up by NSP clients without any financial incentive offered. For those who elect to attend a one-to-one information session with nursing staff, training is tailored to the individual. Typically, experience of overdose is a starting point for a discussion, establishing just what an opioid overdose looks like and distinguishing between a loss of consciousness and a 'heavy nod' in which a user is heavily intoxicated but still breathing. Of great importance is the demonstrated use of the mini-jet pre-filled syringe. As in the group workshops facilitated by HRV's overdose response worker, nurses advise clients to administer naloxone in as simple a manner as possible.

> The best thing that I've come across with it is the enthusiasm of the punters to come on board and, as you say, really feel some kind of control over that concept of someone dropping in front of them, don't know what to do or don't have the whereabouts to do something and to feel that they've got that management, has been something really positive. It's also been a bit of a draw card to Access Health, I think, from people that are hearing it on the street and there's a bit of slang out there about it now and so that shows it's being absorbed into the community and the culture, which is a positive. So, I've been approached on outreach with people's knowledge that I am linked with Access Health, you know, 'Oh, can we come in and talk to you about that?' and the process is so simple and easy and smooth.
>
> People like ... the streamlined approach of coming to see the nurses. One of us is always in the clinic, it's quick to get in, you don't [need to] make an appointment, you don't have to wait to see the nurses, generally you're pretty much in. Then the other good thing is [the doctor on site] is quite open to us just ringing and saying, 'we've got someone in with us,' [and] they'll drop what they're doing and come in and just see the person, make the prescription and we can move on from there pretty quickly (Linda, RDNS HPP Nurse, 21 May 2014).

THE ACCESS HEALTH MODEL
– TAKE HOME NALOXONE

CORE PRACTICAL ELEMENTS OF THE THN PROGRAM

Regardless of the manner in which it is received, clients are trained in how to effectively administer naloxone to an overdose victim. While receiving training, prescriptions written for those clients participating in workshops are filled so that they can take the overdose 'antidote' with them at the conclusion of the session. Thereafter, clients are able to present at Access Health at any time to refill a naloxone script if they have had cause to use their initial dose. The supply of needles is a marked difference to the naloxone kits dispensed by pharmacists upon prescription from GPs working within the COPE program.

Supplying five (comparatively low) doses of naloxone allows the person responding to an overdose to administer a second dose if the first is insufficient to revive the victim (or to revive them again if they lapse back into unconsciousness). In contrast, paramedics generally administer a dose of 2 milligrams and do so intravenously (naloxone mini-jets distributed for use in Australia are suitable for intravenous, subcutaneous and / or intramuscular use). The ability to administer 0.4 mg of naloxone intramuscularly ensures that revival is slow (and relatively gentle). This is important because it provides peers with the capacity to gently revive a person, which is very unlike the unpleasant and rapid removal of all opioids from the brain when revived by ambulance staff using significantly higher doses and injected intravenously. The process of gentle revival has helped to reinforce a sense of agency for users and their peers because it has provided another layer of control over a situation that previously resulted in opioid tolerant users being awoken in a disoriented and aggravated state.

As of 20 April 2015, 218 people had received naloxone through Access Health.[5] This volume speaks to the initial courage that embedded the THN program at Access Health, the willingness to increase the frequency of workshops to meet demand (and the concurrent costs associated)[6] and the readiness with which the targeted community accepted the message being communicated by trusted figures within TSA Crisis Services and especially Access Health and the NSP. By the end of July 2015, workshops were being run three times every two months and some 235 individuals had completed training in the group workshops and been provided with take home naloxone kits. Numbers are not maintained in respect of clients who received naloxone from nursing staff, although these are estimated to be around 15 to 20.

5 Personal communication, Paul Bourke, Manager Access Health, 21 April 2015.

6 HRV pay workshop participants to attend the workshops, and Access Health pays for the prescriptions of the attendees to be filled by a local pharmacist. Given most participants are eligible for a concession rate as holders of pension health cards, each script of naloxone costs Access Health $6.

COMMISSIONING THE RESEARCH

After the initial months of holding workshops succeeded in ensuring an increasing rate of demand attendance of workshops such that they were increased in frequency to twice monthly in 2014. Initial participants were opportunistically recruited as noted above. These first participants became a means by which access to naloxone was communicated to other users in the local community and knowledge of the program diffused through local networks.

At the end of August 2013, staff from TSA Crisis Services contacted RMIT to discuss the design and conduct of research to observe and evaluate the THN program as recently initiated. The aims of the research were to explore the experiences of people accessing the THN program, to understand the effectiveness of the dual path model and its implications for Access Health in resourcing and future program design. At the time of project design, there were seen to be three 'groups' of clients whose experiences might inform the ongoing evolution of the program: those who had participated in workshops; those who had been trained in the appropriate use of naloxone by nurses at Access Health and those who had, when offered access to overdose response training (and an incentive payment for attending said training) had declined the offer. Interestingly – and encouragingly for the program – those clients of the adjoining TSA Crisis Services who, despite being opioid users or their peers, had voiced their decision not to become involved in the THN program dissipated over the course of this research. Suggested reasons for this are discussed later in this report.

Communication between key staff at Access Health and RMIT resulted in a project design being agreed upon in late 2013. An application to the RMIT Human Research Ethics Committee was submitted (Reference number: 02/14) in December 2013. Ethics approval was received on 31 January 2014 and final planning meetings held between the research team and Access Health management thereafter.

Between 20 February and 15 May 2014, 18 interviews were conducted with clients who had participated in overdose response workshops. Interviewees were recruited in the very same manner as participants in naloxone workshops. Participants were recruited opportunistically through the NSP and Access Health. Clients accessing services at the NSP were informed of the research and asked about their willingness to be interviewed about their experience. Staff at the NSP sought participants that had either completed a workshop, used naloxone or who had previously stated that they did not want to engage with the THN based on an idea they believed the provision of naloxone was problematic. On occasion,

COMMISSIONING THE RESEARCH

scheduled interviewees were unable to attend and staff, at the NSP or Access Health, opportunistically recruited former workshop attendees on the day. In this way, 14 men and four women participated in interviews. Three couples (male and female) were recruited and interviewed. In each case, the couple had attended workshops together. Although nursing staff continue to provide an alternate pathway to access naloxone, after further consultation with Access Health management and staff it was decided that interviews would not conducted with those who received naloxone via this avenue out of concern for client / practitioner confidentiality.

During the interviews clients talked about becoming involved with the THN program, their experience of engaging with the program as currently designed, their personal and peer experiences of overdose, their understanding of naloxone, if they had used naloxone and their thoughts on how the availability of naloxone had changed anything related to their practice of drug use or changed anything for their community? Interviews were also conducted with Access Health staff, notably a member of the nursing staff who had conducted a number of face-to-face training sessions in overdose recognition and naloxone administration with individual clients. Interviews were open-ended and conversational in nature.

Supplementary information regarding the running of the program, throughput data and information on implementation and process issues were documented via personal communications with Access Health staff and the DOPE worker employed at HRV.

PARTICIPANT'S EXPERIENCES

PATHWAYS INTO THE WORKSHOPS

The clients of the TSA Crisis Services NSP who participated in workshops provided contact details to NSP staff in the interests of attending the next available workshop. A number of participants who subsequently partook of this research were candid in acknowledging the monetary incentive as the primary motivation for signing up for workshops. Encouragingly, the same interviewees recognised the valuable nature of overdose response training, and the opportunity to be equipped to respond accordingly, if necessary:

> This is what happened to me. I just thought of the $20. I didn't really know a lot about [the workshop] until I did it. When I got there first, I said, "Oh, so how much are we getting paid?" That's what I said, you know. And I sort of stopped and looked at myself and went, "Well, what's going on here? You don't usually think like that." That was old behaviour. But it just crept in and then once I started doing it I'm like, "Hey, this is actually what I need to do. It's interesting and it's something that's going to help me, make me feel, like I said, in more control" (Brian 24 May 2014)

> There were two other working girls [at the workshop]. I noticed them on the street straight after ... I said that was pretty good don't you reckon? They're, like, 'what, the cash?' I go, 'No the naloxone, I feel safer using now that we've got that.' They were, like, [after a moment's thought] 'yeah actually [it was].' I realised once they thought about it, that it did do something [for their knowledge and capacity to act in the event of an overdose] and it did something for me [in that way too] (Kassie 14 May 2014)

THE WORKSHOP AND THE MESSAGES PROVIDED

One of the evaluative aims of our research was reviewing the workshop element of the THN program. It soon became clear that the peer nature of the HRV led workshops was pivotal in the acceptance and uptake of the program. Explaining the nature of the workshops she facilitates, Jane Dicka, HRV's overdose education trainer outlined the following descriptive explanation of workshops:

> Our training aims to put naloxone administration into context so we cover more than just the administration part. We start with what causes an overdose and how to prevent it, then we cover how to recognise an overdose and then, in the event of an overdose, what to do including how to administer naloxone. We also cover other effective ways to respond to an overdose including rescue breathing (mouth to mouth) and we discuss things like the pros and cons of calling an ambulance and police attendance at overdoses. While the naloxone administration part is a very simple procedure, attending an overdose is still a highly stressful situation. I've lost count of how many overdoses I have attended yet I'm still overcome with fear and panic ... I think it's only natural to react with panic to every overdose you witness, no matter how many times you've been there and done that.
>
> Another one that comes up often is...'If I've got naloxone, do I still need to call an ambulance?'
>
> It's always better to call an ambulance and get professional medical help on the way. I think it's kind of obvious. However, I do understand that there are times and reasons why calling an ambulance might not seem like the best thing to do (HRV 2014a)

PARTICIPANT'S EXPERIENCES

EXPERIENCE OF OVERDOSE

The fact that most of those interviewed spoke of having being confronted, conflicted and, ultimately, feeling powerless when faced with opioid overdose prior to their training underscored the value of the opportunity offered by the THN program. They spoke of their previous experiences with overdose – most of having to call and then watch paramedics revive an unconscious friend or acquaintance. At least two participants spoke of having used cardio-pulmonary resuscitation (or CPR) to ensure continued oxygen to the victim's brain – but professional medical attendance was still necessary to ensure the victim regained consciousness. Others spoke of having seen friends die, despite having been present to revive them, and the experience of being powerless without the knowledge and means to do so. Experience of overdose, as noted above, is common among opioid (and particularly heroin) users and research participants confirmed this. This overwhelming and lasting sense of helplessness was recalled by participants who had the time and desire to intervene, in the obvious distress of another, and was an experience that was seared in their memory, given their inability to do so. Indeed, many carried memories of fatal overdoses that weighed heavily on them, particularly if they had left the overdose victim for fear of police attending.

> I deal with this every single day, I have felt like I've done what I've done, I've called the ambulance and I've ... gone [left the house in which an individual had overdosed]. And [the other people there have] just gone. And that doesn't sit well with me. That happened when I was very young and the person died and she left her two daughters in the house ... so [now] I don't care about the politics. I don't care what sort of trouble I'm going to get in. I don't give a shit. That's someone's life ... If you're going to get caught you've got to, you know, take on the responsibility of what the actions are going to be. So that's the way I look at it these days. I'm staying there till help comes (Brian 24 May 2014)

THN DISPELLING HARMFUL OR USELESS MYTHS ON OVERDOSE

One participant spoke of his immediate intervention if he witnessed any signs of overdose (e.g. shallow and slow breathing; lips turning blue). For the young man in question, this meant, after having called paramedics, using the benefits of his first aid training. However, the limitations of what he was able to do while waiting for an ambulance to arrive – a period that could mean the difference between irreversible brain damage and little if any ill effects at all – meant he had used sometimes counterproductive means to attempt to revive the victim. This is given added emphasis by the fact that efforts to revive comatose overdose victims – in the absence of naloxone and overdose response training – led some participants to administer a sharp slap to the face or sit the victim in a cold shower (a response that could further slow an already depressed respiratory system or put the victim at risk of hypothermia) (Oldham & Wright 2003).

As soon as I see a sign of something [indicating overdose] I'm one of those people that will call the ambulance. And I'll call the ambulance and then go through the procedures myself and do what I - because I've done first aid and everything, and do what I need to do. But it's always just the old cold shower, the shaking, moving [the person about to try to revive them], whatever I can do, put them on their side. (Brian 21 May 2014).

While some research participants observed other attendees at workshops clearly under the influence of drugs, the HRV worker's peer knowledge and lived experience were key to establishing a willing and attentive group. All spoke highly of the content of workshops and their facilitation. Almost all participants expanded their knowledge of how to best respond to cases of overdose. For some, it was a case of correcting misguided beliefs about how to respond to a heroin overdose. At least two research participants reported that, prior to attending the workshops, they thought overdose victims were revived by means of an injection into the heart (after, presumably, puncturing the breastbone). An infamous (and widely known) scene from the 1994 film Pulp Fiction saw a victim of heroin overdose revived by the (demonstrably violent) plunging of a large syringe (supposedly containing adrenalin) through her breastbone and directly into her heart. The messages communicated by popular culture – and the potential danger of these being incorporated by a community whose activities are, by virtue of their criminal nature, still averse to honest education, could not be more graphically illustrated. Others thought naloxone should be injected intravenously as opposed to a muscle. While this response is used by professional medical responders, training to administer naloxone into easily exposed muscle mass avoids any potential complications associated with finding a vein and / or damaging that vein. Debunking myths and providing accurate information instilled confidence in participants and was instrumental in the efficacy of the HRV facilitated workshops.

EMPOWERING USERS TO ACT THROUGH KNOWLEDGE, CONFIDENCE AND THE RIGHT GEAR

As implied immediately above, all participants talked of their confidence in responding to an overdose in future. This was significant – not only did workshops debunk established myths within the IV drug using community – they engendered the means of negotiating the 'politics' of reviving someone. The angry response of overdose victims who have been revived with a large, intravenously administered dose of naloxone by paramedics, (the source of tabloid fixation of the 'ungrateful junkie') has, interestingly, been somewhat addressed by allowing peers to administer the drug in lesser dose via intramuscular administration. The incorporation of naloxone in overdose response training has allowed drug users to talk to others within their community about the need for, and benefits of, the drug.

I do feel a little bit in more control with having this [naloxone] offered to me. Like when I found out about it I thought to myself, yeah, that makes me feel even a little bit safer to have that. I don't know how many people go to the doctors, get the script and everything but I really would stand up and say it's worth doing because I feel like I have a little bit more control because watching your best friend's life go out of their eyes is just the worst thing, as you probably - as you guys would know, is the worst thing you can ever witness, you know. I mean, I've found people hanging in my shower and just lots of really bad stuff, you know, that everyone else is a witness to as well. So, yeah, any time there's a life there, I can actually take something and go bang and it'll help. I feel like I've got a lot more control in that situation (Brian 21 May 2014).

PARTICIPANT'S EXPERIENCES

For some participants confidence had extended beyond talking, to a preparedness to intervene to reverse incidents of overdose.

> I think she gave us more confidence in [responding to an overdose] ... when that night happened [and we were faced with two overdose victims] we knew what we had to do (Fiona, 10 March 2014).

In contrast to feelings of powerlessness, a new sense of agency was reflected by a strong desire to assist others. Even if workshop participants did not hear 'new' information within the course of the training workshops, they could confirm their existing knowledge with the previously unattainable means to respond in a meaningful way. This combination of knowledge and capacity was clearly reflected in the greater sense of agency reported by those who participated in interviews:

> It's amazing having that feeling [of being able to respond to an overdose]. I mean, my partner has got a naloxone kit but, doesn't use [heroin], but knowing it's there [makes me feel safer] ... [Users in the community know they] have to look out for each other so they've each got their own kit. One person drops and the other, you know, can take care of that person. And it makes such a difference (Brian 24 May 2014)

Importantly, the ability to address the immediate effects of overdose without the once required call to medical authorities underscored the agency granted to those who participated in workshops. This was reflected as a key aspect in the acceptance of the program.

NALOXONE IN ACTION

Four of the 18 participants who participated in research interviews had revived overdose victims in the weeks after having completed the workshop. These actions comprised the strongest evidence of the efficacy of the THN program and its impact on workshop attendees' behaviour (along with a sense of agency sufficient to act in a life-threatening situation), is arguably the key legacy of the program. Further, of those aforementioned four, two no longer used heroin (or any opioids). These individuals spoke of having grown tired of 'the life' and of having lost too many friends to overdose. Wanting to stop such preventable and needless loss of life these individuals were indicative of many who received training to overdose response to equip themselves with the knowledge, skills and equipment to revive others.

> ... having been through the 90s and burning my last suit because I said, 'I'm never going to another funeral' ... as soon as I read in the paper, maybe three months before [a worker at the NSP] told me, I read a tiny, little article in the paper, this big. It said, 'Naloxone has been approved for addicts'. I thought, 'wow, what does this mean?' I came in and I asked and it was about three, four weeks later finally Finn told me, 'There's a [workshop] coming up and as soon as it's on I'll let you know'. That's why I wanted to get it as soon as I could, because to me it's [just common sense]... the girl I [revived] the other week probably would have died. May well have (Chris 10 March 2014)

We both did the workshop. We both had two pens each in this thing, so we knew everything. The only reason we got them is because of the amount of people that OD at our front door. That's the only reason we got them.

So not so much for yourselves?

No, no, it was just because - and also Craig used [heroin] in the 90s and 80s and he went to three funerals a week back then [due to friends overdosing]. You know what I mean? … [Now] It's a totally separate thing, because we were having people 'drop' at our front door all the time … So we just thought, bugger it. The most upsetting thing that has happened is me thinking, what if we didn't have it with us? I just keep thinking, imagine if we didn't … thank God we had them on us (Fiona 10 March 2014)

THE ADOPTION OF A GOOD IDEA BY THE COMMUNITY

As a new and innovative idea, educational workshops had to be embraced by the targeted, local community. Evaluative research of drug-related harm reduction interventions have long recognised the importance of respected peers facilitating wider acceptance of new strategies (Wagner et al 2013). This is particularly the case for state sanctioned health strategies given the criminal status and continued prosecution of injecting drug use. The acceptance and approval of naloxone by those seen as knowledgeable figures is seen a powerful means by which a new strategy might be accepted throughout the local drug using community. There were three such points at which the THN program was validated in this manner.

A number of participants mentioned that the staff of the NSP and / or Access Health who had first brought their attention to the THN program were people they had interacted with on a regular basis. These interactions had promoted a trust relationship built on mutual respect and shared knowledge of their experiences. The genuine concern shown for clients' wellbeing had positioned certain staff members as people to whom clients listened, and to whom a sense of membership within their community was extended. When a trusted member of their community talked about the opportunity to participate in workshops or educational practices, interviewees suggested this was enough for them to explore the option further. A number of mature age injectors, with self-identified relationships with workers at the NSP and / or Access Health, identified their relationship with the staff member publicising the opportunity to participate in training as indicating to them that to undertake this training was something worth considering. In essence they translated the value in their relationship with the worker into the probable value of the intervention.

Secondly, the facilitation of the workshops by a knowledgeable peer with firsthand experience of heroin use and overdose led to a respectful and attentive audience – even in those instances in which much of the information was already known to workshop. The value of peer education has been well established as a means of facilitating behavioural change, particularly in areas of health promotion (UNAIDS 1999). Peers are of great value in innovative strategies such as that represented by the THN program for a number of reasons identified in international public health literature. These include, but are not limited to, peers providing a credible source of information and one that is more effective than professionals in passing on educational information due to this credibility (e.g. Clements & Buczkiewicz 1993). This can be especially important when engaging with a group that has long endured discrimination, both deliberate and unintended, when dealing with mainstream medical professionals and health services (Abouyanni et al. 2000; Centre for Harm Reduction 2000; AIVL 2010).

In contrast to the separation engendered by the professional status of medical practitioners, a peer educator is of equal standing and, in the case of injecting drug users, a member of the same 'subcultural population' as their audience, membership of which is defined by engaging in what is both criminalised and

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highly stigmatised behaviour. This labelling of their mutual behaviour strengthens the association between peers and validates experiences seen as illegal within the broader community. Consequently, when an authoritative member of this peer group provides education and training in relation to a program that is clearly in their interests, the audience is far more inclined to recognise the value of the program being explained. For the same reasons, peers are also more able to educate those who are hard to reach and exist beyond the reach of mainstream education (i.e. because the education they offer is acceptable whereas mainstream education is not (e.g. Turner & Shepherd 1999). In this way, the peer education process was critical in the success of the THN program.

Finally, and perhaps most importantly, older and authoritative members of the local injecting community spoke of the value of the program. The targeting of articulate, knowledgeable and experienced members of this local community by NSP staff seems to have been instrumental in the acceptance of the peer-based program. Certainly, interviewees noted that the THN program had been accepted due to the endorsement of the program by respected individuals in the local drug using community; creating an 'instinctive desire' amongst others within that community to take part in the innovative peer-based strategy. When senior and long-standing members of the local drug using community heard about, attended and gave their blessing to the program, this represented an important step in providing the credibility needed for rapid acceptance of the program.

> At first they [in the local injecting and transient community] weren't going to do it. They thought it was just bullshit. I said, 'It's not bullshit, you may as well do it.' And the reason [this was seen as authoritative evidence for its benefits] was 'cause I was in the same boat as them guys. I take drugs with them guys ... If you went and told them or the doc went and told them, they'd say, 'what would you know, mate? You're not part of the group, what would you know?'
>
> You've got to be actually in the [group]. As I say half of them [in the community were] like me. When I went to rehab, I had a counsellor who tried to counsel me, and like, I'm, 'have you ever been on the street?' 'Nuh.' 'Have you ever [done] anything [remotely similar in terms of living my lifestyle]? 'No, I read it all out of a book.' 'Well, don't talk to me mate, you haven't got a clue what you're talking about.' If you've been there, you've done it, people want to listen to you. If you haven't been there and done it, and you're read it out of a book, they don't want to listen to you. No one the street will listen to you (Nigel 21 May 2014)

AN IDEA NO LONGER REJECTED BY ELEMENTS OF THE COMMUNITY

The speed in which the value of naloxone was communicated was reflected by the need to schedule training workshops at a greater rate than the initial timetabling of once each month. The necessity of running two workshops per month was evidence of not only a rapidly spreading idea but also an idea that had been accepted and embraced. Initially Access Health had identified a group of clients they believed would be unwilling to participate in the workshops and negatively associated the use of naloxone with their experiences of being revived by ambulance officers. For the six months between when the THN program commenced workshops in August 2013 to the scheduling of interviews for this research, this group had presented as a small but concerning group. However, the adoption of the THN program by the community and individual's capacity to communicate the value of being able to respond to an overdose, changed the opinion of those who had been opposed. By March 2014 not a single community member opposed to the provision and use of naloxone could be identified for interview. Further discussions with NSP worker revealed that even those who had been very vocal in their opposition had subsequently decided to attend a workshop.

HAS THE MODEL WORKED?

ADOPTION OF THE MODEL BEYOND ACCESS HEALTH

The success of the Access Health model (and particularly its engagement of the dedicated Drug Overdose Prevention Education worker from HRV to facilitate the workshops) was indicated by the rapid spread of the model. The positive feedback from participants and the successful reversal of overdoses is clearly a key factor in this success. Further, the absence of any negative consequences or perhaps, more specifically, any action on the part of the government to either put an end to the peer-based workshops or bring them under the control of the COPE program, proved the impetus for the peer-training workshop model to spread beyond Port Phillip. Indeed, Access Health and others encouraged to act by its example have also become early adopter sites of practitioner based, one-on-one, naloxone distribution. Jane Dicka, the dedicated DOPE worker at HRV reported in her naloxone update on 20 February 2014, other services had engaged the idea precisely because Access Health had, in her words, 'had the courage & compassion to 'just do it'' in terms of implementing a proactive response instead of waiting for the government-sponsored program to work its way through the required bureaucratic processes of the evaluation and subsequent restructure of Victoria's non-residential drug and alcohol sector. These front line services began to emulate the Access Health / HRV workshop model in 2013/14. Workshops were soon being facilitated by Jane at 'Taskforce' in Moorabbin (30 September); North Richmond Community Health Centre (22 October); Health Works in Footscray (3 December); and Innerspace in Fitzroy (5 February 2014).[7]

OVERDOSE REVERSALS

The other main indication of the success of the Access Health model is the fact that it has proven a capacity to reverse (and thus prevent) overdose. At that early stage, HRV DOPE worker Jane had delivered 15 workshops to 120 people and reported 11 overdose reversals (HRV 2014b). In the most recent naloxone update provided on the Harm Reduction website, Jane had facilitated the training of 475 peers in workshops – each had left the site of their training with a take home naloxone kit. There had been, to her knowledge, 60 overdose reversals attributed to drug users administering the naloxone distributed after training in workshops (HRV 2015). Given the anecdotal nature of these reports – and the continued criminal nature of heroin use that works against individuals coming forward to officially report overdoses and the subsequent responses of peer witnesses – the number is almost certainly much higher.

EFFICACY OF A DUAL PATHWAY MODEL

While it is clear that the peer-facilitated workshops have been instrumental in both facilitating the community's incorporation of naloxone into the routine of their drug use inasmuch as such exists, (for example, the choice by many individuals to include a THN kit as part of their own harm minimisation approach), it is less clear that the nurse provided training sessions have been utilised by the community to the same extent. This is significant as this element of the THN program represents the initial COPE approach to the implementation of the policy goals.

7 Personal communication, Jane, Harm Reduction Victoria Drug Overdose Prevention & Education worker, 21 April 2015.

While the COPE model has grown to include the provision of a workshop model for PWID and family, these are not specifically peer-facilitated, nor do they include the provision of naloxone. The peer-facilitated workshops represent a more than 10 to 1 acceptance ratio by the community over the nurse based one-on-one training provision at Access Health (235 workshop participant compared to 20 nurse trained clients). While the workshops do provide an incentive of $20, clients have to pre-book and then coordinate life events in order to attend. While the nurse based training option provides no cash incentive, it can be provided on the day or appointment based (whatever a client prefers). While the provision of this pathway provides no additional overhead for Access Health and may actually provide clients with the opportunity to engage with the nurse on health matters beyond naloxone, the difference in uptake between the two pathways does raise concerns for the efficacy, in terms of reaching the PWID community, of the initial approach under the COPE model as initially provided. This is particularly the case given that Access Health currently chooses to fund prescription costs for both pathways, while the actual provision of naloxone via the COPE based approach is funded by the client.

WHERE TO FROM HERE?

The greatest priority is the continued distribution of naloxone into as many hands as possible. Access Health does not maintain data on how many workshop participants have returned to refill their initial naloxone prescription. However, if the aim of community distribution of naloxone is to prevent overdose, then the peer-based workshop model is clearly working. Further, the integration of Access Health as an early adopter of the COPE model has allowed the two models to complement each other (albeit with a significant emphasis by the community on the workshop pathway). The ability of clients to access naloxone through nurses on a daily basis means that there is no need to wait for a timetabled workshop. However, the incentive remains as an added impetus for those of the target group who may prove harder to reach via the formality of an individual meeting with a medical practitioner.

Access Health cannot provide any data on the number of naloxone refills provided to clients and it would be important, moving forward, to gain an understanding of naloxone's use by members of the community. This information would be important in speaking to the efficacy of naloxone in action and also to understanding the cost implications for the organisation. If the number of script refills remains relatively low, this would suggest the provision provides a vital capacity within the community at a low, almost one-off cost. If script refill numbers are significant, then it is clear that the community is benefiting enormously and whatever sustainability issues this raises for the THN program will need to be addressed.

A clear finding of this research has been, in the HRV DOPE worker's words, the unexpected outcome of how beneficial the peer-based nature of the program has been for the self-esteem and wellbeing of drug users and their family and friends who have participated in the program. The program is based on recognising not just the willingness, but the ability of heroin users (and the other users of illicitly obtained opioids) to save lives.[8] This provides a 'wealth of responsibility' and, in return, the empowerment that comes from saving another's life. This stands in stark contrast to the stigma and discrimination encountered by those who are identified as illegal – and injecting - drug users (see for example AIVL 2010).

8 Personal communication, Jane, Harm Reduction Victoria Drug Overdose Prevention Education worker, 21 April 2015.

HAS THE MODEL WORKED?

SUSTAINABILITY – ARE WORKSHOPS STILL NEEDED?

On questions of cost, the continued payment of financial incentives for attendance at group workshops is an issue deserving consideration. Indeed, some might question the need for workshops as a continued means of providing training to groups given that they have been running on a regular and continuing basis since August 2013. Given the costs of paying for attendance and the need to schedule appointments and organise the workshops around the availability of the respective HRV DOPE worker, the validity of continuing with this approach is worth considering. The ability and willingness of nurses based at Access Health to provide individually tailored training as part of their professional interaction with injecting drug users – and as a COPE site – may well be sufficient to meet remaining demand. Currently, however, the data doesn't support this. Certainly, the general health care that nursing staff already provide to minimise the potential harms caused by injecting drug use provides a viable opportunity to introduce information on the availability of THN and its use in the case of overdose. This is particularly so if clients are aware of the ongoing ability to access training in overdose recognition and response when meeting with nurses at Access Health.

Despite the number of workshops held, staff at Access Health report they are yet to reach saturation point in the local community. The ratio of locals from St Kilda and the broader Port Phillip community, to those attending from other parts of Melbourne (or wider still) has remained constant and would suggest that there is still local demand for workshops.[9] Further, the payment of incentives has continued to the time of writing (31 July 2015) for very good reason. According to management at Access Health, there remains the potential for there to still be members of the injecting drug using community who would not access naloxone without the incentive and these might be very important people to reach in terms of living a more transient and what might even be termed a chaotic lifestyle. The timing of the workshops – on a specific time and day, means there must be some degree of planning and organisation inherent in the ability to attend one's appointed workshop. However, the need for money may be the additional motivating factor required get some of the more marginalised populations to workshops.

Admittedly, due to the offer of payment for attending the HRV facilitated workshop, some clients who already have appointments with the nursing or medical staff at Access Health, choose not to use these appointments to access naloxone despite being aware of the ability to do so. This may be one of the reasons for the fact that peer-facilitated workshops are the overwhelming avenue through which participants choose to avail themselves of training as part of the THN program. Unfortunately, given its scheduling at a future date and time, those who put their names down for a workshop may or may not, end up attending. However, staff at both Access Health and the NSP were able to opportunistically recruit participants when workshops were being run to optimise the workshop attendance. It should be noted that while nurses initially provided an alternative means for those simply unwilling or unable to attend workshops, they now do so as part of the State Government funded and Penington-Institute-administered COPE program.

A number of participants in the research spoke of the need for wider advertising of the availability of naloxone from Access Health. At the time of

9 Personal communication, Paul Bourke, Manager Access Health, 30 July 2015.

the interviews, seven months into the program, a number of interviewees were not aware of the option of receiving training and naloxone via nursing staff until this option was mentioned by researchers. However, the significant time that the program has now been running has allowed communication on naloxone's availability to be shared throughout the local injecting community. Further, in personal communication with staff, by July 2015, anecdotal evidence suggested that more clients at Access Health were asking staff about the availability and means of accessing naloxone than the number of persons being informed of the availability of naloxone by staff. This is further evidence of the community's adoption of naloxone as part of members' ongoing commitment to harm reduction.

The peer training and distribution model begun by Access Health stands in sharp contrast to the COPE program begun in late 2014. Despite the initial vision of a widespread community distribution of naloxone in Minister Wooldridge's Press Release, the initial focus at 'early adopter' sites has been on training General Practitioners (GPs) and other primary health care professionals (including nursing staff and pharmacists) with the intention that these professionals bringing naloxone to the attention of those of their patients to whom the drug is relevant and prescribing it to them. This is not to suggest that the focus on peer-based distribution is no longer an aim of COPE. It remains the first of four identified populations on the Penington Institute online explanation of the COPE strategy (Penington Institute u.d.). Indeed, staff at Access Health were keen to emphasise the contribution made by the COPE program as opposed to acknowledging the ground-breaking step they had been party to in initiating the first program by which naloxone was distributed to users and peers solely on the basis of the willingness of people to attend training in overdose recognition and response. Certainly, the provision of up-to-date information and training materials – and concentrating this training on practitioners to complement the community health focus on peer networks provided an efficacious example of complementary strategies in action. The extension of COPE beyond urban Melbourne to regional and rural locations locations throughout Victoria was notable given that health professionals offer the most discrete means through which consumers might be introduced to, and prescribed naloxone. Peer-based workshops are not possible in smaller communities without compromising the confidentiality of the identities of potential participants. This informed the initial focus of the COPE program at 'early adopter' sites where practitioners could raise the subject in a confidential setting. In 2015, the Penington institute reported that, as of May 15, the COPE program had oriented almost 100 community service agency managers in relation to the benefits of providing naloxone to clients. As just one example, the drug treatment agency Windana has made naloxone education and provision a standard in delivering its drug detoxification program.[10] Further, more than 215 frontline workers at these services had been trained in overdose recognition and responding with intramuscular naloxone injection as well as how to conduct training with users and their peers (Penington Institute 2015). This included staff at Access Health and was part of the aforementioned contribution of the COPE program.

The manifold benefits of the COPE program clearly complement the peer-training model. However, any model of naloxone distribution that is dependent on contact with medical professionals, or even front line staff of agencies such as Access Health, cannot replicate the value of a peer-led (and peer-distribution) model as demonstrated by the first naloxone distribution program within the state. A model facilitated and 'owned' by peers does not face the potential for 'cognitive dissonance' on the part of medical practitioners who are unused to, and distrustful of, a model that seeks to put the treatment – i.e. administration of a (then) Schedule 4 drug – into the hands of drug users and their peers as opposed to medical practitioners. Nor does the service based program face the potential for opposition to any expansion of COPE to encompass distribution of naloxone to the wider public for fear that such a strategy may be seen as accepting and accommodating the criminal use of drugs, a perception that has constrained the adoption of other harm reduction strategies in Victoria, Australia (e.g. Jefferson & Johnson 2015). The research participants articulated the advantages of the peer-led model developed with Harm Reduction Victoria and delivered at Access Health. The effectiveness of this approach was also reflected by its subsequent adoption by a number of inner-urban community and primary health care centre in the months after it began.

10 This is particularly pertinent example given the vulnerability to overdose if the detoxification period has been sufficient to reduce an opioid tolerance levels.

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Clearly policy makers involved with the expanded provision of naloxone have a practical understanding that, even though a script for naloxone is provided to a specific individual, that an individual cannot self-administer a drug to 'reverse' their own overdose. While the findings of this research suggests that the community is more than willing to adopt naloxone as part of their own personal harm minimisation strategy, it is also clear, as articulated by many, that they will 'look after' one another now that they have the capacity to do so. Exploring the reasons for the success of the THN peer-distribution program pioneered at Access Health has provided space to consider how the documented benefits might be expanded upon. At the very least, we must acknowledge that the THN program has demonstrated that real change can still be achieved. Those wishing to further the adoption of harm reduction in drug policy should see the continuing expansion of naloxone distribution as reason for optimism. Certainly, the political decision to sanction the training and distribution of naloxone to peers represented a departure from the criminal justice prioritisation of a law enforcement response to protect society from stereotypical caricatures of irresponsible, dangerous drug users. Access Health's long embrace of a harm reduction approach – in a real sense –recognises illegal drug users as socially responsible members of their own community, and of the broader community of which they are members. The continued stereotypes that define injecting drug users in the public sphere, marginalised by mainstream media (mis)-information continues to obstruct effective policy responses. In this context, it was, for many, an unexpected step for politicians to place themselves outside of policies that purport to be 'tough on drugs' in recognition of the harm caused by these same policies. Actively addressing some of the consequences of the thinking that has accompanied prohibitionist policies – such as confining the possession of naloxone to medical 'professionals' – should provide some momentum for policy makers to pursue further change. It is in this spirit that we offer the following practical recommendations.

1. FUNDING BE PROVIDED TO EXPAND TRAINING WORKSHOPS IN OVERDOSE RECOGNITION AND RESPONSE USING NALOXONE.

The success of targeting training to opioid users' peers suggests there would be a benefit to expanding the program to include workshops designed for people beyond the immediate opioid using community. Family and friends, parents and partners (i.e. the people most likely to find someone who has overdosed in their home) would readily accept the opportunity to receive such training and store naloxone with other medications and first aid supplies in the home. Family members have spoken of, not just their willingness, but their strong desire to be equipped to respond to the overdose of a loved one (e.g. Strang et al 2008; Williams et al. 2014). Indeed, the initial press release of then Community Services Minister Wooldridge specifically mentioned family members when talking to the distribution of naloxone beyond medical professionals (Wooldridge 2013). The provision of naloxone is not only a potentially life-saving component of a household first aid kit. It is also a means of addressing, if

not remedying, the constant anxiety that can dominate the lives of parents, partners and those who care deeply for the welfare of individuals they know to be using opioids, whether heroin or pharmaceutical in nature.

Research participants provided illustrative examples of how attending peer-led workshops can provide the first-hand knowledge and capacity to respond to a situation of overdose. While four of the 18 interviewees who participated in overdose recognition and response training no longer used, all four lived in what could be termed communal settings, either boarding/rooming houses or cheap hotels in St Kilda, settings in which injecting drug use is common. For these individuals, the training afforded them the opportunity to respond in the case that a neighbour or local resident overdosed on heroin. Even when the financial incentive was the initial motivation for attending the training, the knowledge, capacity and ability to respond to such a situation saw these individuals – many of who had been emotionally affected by their powerlessness to revive overdose victims in the past – articulated a newfound confidence if confronted by an overdose in future. One couple, after having admitted to being persuaded to attend a workshop by the 'easy' $20 paid as an incentive for undertaking training, shortly thereafter revived two women who had overdosed on a combination of heroin and alcohol in a car park opposite their rooming house. Another interviewee spoke of ensuring that, when using heroin or other opioids with his peers, somebody had naloxone with them in the event of an overdose. He had already been compelled to use naloxone provided by Access Health to revive a peer who had overdosed after injecting heroin he had mistakenly believed to be amphetamines:

> … say we was just going for a shot, someone else was coming for a shot, well we'd probably make sure one of us had it just in case. Like when I go with the people I go down [to use heroin with], … when we go down, [we] make sure someone's got [naloxone] just in case (Nigel May 2014)

2. THAT STEPS BE TAKEN TO ALLOW PRIMARY NSPS AND COMMUNITY HEALTH SERVICES – SUCH AS ACCESS HEALTH – TO DISTRIBUTE NALOXONE TO CONSUMERS AND CLIENTS.

Training workshops were clearly a part of the process by which naloxone was accepted and incorporated into drug use practices of local of PWIDs. However, the decision taken by Ballarat Community Health Services to dispense naloxone to clients via the on-site NSP represents a commendable initiative as a more immediate means of increasing access to naloxone. The rationale provided by the TGA for a separate Schedule 3 listing speaks directly to this outcome with its emphasis on full and clear instructions for use by consumers. An investment in naloxone, purchased over-the-counter by community health services, distributed by primary NSPs and targeted health services, could be the optimum means of putting naloxone into the hands of those who use opioids. Publicising the availability of naloxone via these services could ensure access for anybody who may need to respond to an overdose. It is important to take note that scheduling regulations continue to apply to naloxone and that, as a Schedule 3 drug, it is categorised as a 'pharmacist only medication'[11]. This means the supervision of a pharmacist is required (as is the case in the aforementioned example in Ballarat). The pragmatic decision to implement dual scheduling of naloxone was taken to facilitate ease of access to the drug. The authorisation of qualified health practitioners, such as nurses, to dispense naloxone to service consumers would further enhance access while ensuring appropriate levels of professional scrutiny and instruction.

If an affordable option for appropriately staffed community health services, the dual scheduling of naloxone would allows more efficient distribution of naloxone. During workshops conducted at Access Health, staff organised prescription for each attendee, submitting these in bulk to a community pharmacy with the aim of filling the scripts

11 The regulations that apply to over-the counter' medications are determined by the TGA and can be found at https://www.tga.gov.au/australian-regulation-over-counter-medicines

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to supply participants with naloxone at the conclusion of the workshop. This led to logistical complications with sourcing Medicare details, creating client profiles for new clients within the Access Health database, and hoping to have scripts filled in time to pack individual kits for distribution at the end of workshops. An unforeseen breakdown in the process (i.e. the lack of Medicare details or the pharmacy being unable to fill the bulk script in the limited time available) means workshop participants may be compelled to leave the workshop without a kit. Accessing naloxone over-the-counter avoids such concerns. Further, the accessing of bulk amounts via warehouse chemists could provide a significant reduction on price.

The use of Access Health as a site for community information sessions to better equip clients with information to protect themselves when using drugs, has made the harm reduction role of the service clear to inform clients. The further evolution of the peer-based approach to naloxone distribution at Access Health, in conjunction with the COPE program, is necessary to continue The Salvation Army Crisis Services' response to clients' needs and demands.

3. THAT THE AGENCY AND EXPERTISE OF DRUG USERS CONTINUE TO BE ACKNOWLEDGED AND INCORPORATED INTO THE DECISION OF POLICY THAT AFFECTS THEIR LIVES. THIS ACKNOWLEDGEMENT SHOULD UNDERPIN A BROADER COMMITMENT TO CLIENT-INFORMED PRACTICE.

The Salvation Army Crisis Services has long been based on a model of client-informed innovation in the design and delivery of services. This long established approach has informed practice since Crisis Services initial existence as the Crossroads Youth Project that moved to St Kilda in the mid-1980s. Listening to the needs of those using the service has led to the growth of the service as The Salvation Army Crisis Services has invested in meeting these needs. Designing services on the basis of the lived experience of clients has underpinned the efficacy of these services – an approach valued by clients of the Crisis Services Network.

The story of the Take Home Naloxone program is a testament to drug using community's advocacy for change, to policy makers who were brave, to a service that was willing to step off the edge, and to the community that was willing to embrace naloxone and the agency it provides them in caring for each other. Just like the broad adoption of harm minimisation by this community previously, the provision of naloxone has demonstrated that once structural barriers are removed, this community – like any other – is willing to 'Get up, Stand up' and work towards their collective wellbeing.

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