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THE NTA OVERDOSE AND NALOXONE TRAINING PROGRAMME FOR FAMILIES AND CARERS

NHS
National Treatment Agency
for Substance Misuse

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In the past three months, I've prevented two people from going over, thanks to the training. Imagine how much devastation that would have caused otherwise."
Trainee

In 2010 the NTA helped 16 pilot sites across England to train the carers and relations of opiate misusers to respond to drug overdoses and use the antidote naloxone.

The project appears to have helped save lives. This was despite difficulties with recruitment, and limited evidence that carers are the most appropriate people to receive the training. While those carers who were trained said they found it valuable, a wider impact may be possible if the training focuses on all service users at risk of opioid overdose.

An overview of the main findings of the project follows, along with advice for local areas interested in setting up their own training programmes for carers.

The appendices provide more detail about how the project was run and how the sites were evaluated.

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The National Treatment Agency for Substance Misuse, 6th Floor, Skipton House, 80 London Road, London SE1 6LH
T:020 7972 1999 **F**: 020 7972 1997 **E**: nta.enquiries@nta-nhs.org.uk **W**: www.nta.nhs.uk August 2011

1. THE BACKGROUND

- Naloxone is an antidote that rapidly, but temporarily, reverses the effects of heroin and other opioids Among the effects of heroin that can be reversed is suppressed breathing – meaning naloxone has the real potential to save lives

- To avoid the risk of a further overdose after receiving naloxone, users should not take any more drugs. Even if naloxone has been used, an ambulance should always be called to an overdose so that further naloxone and other treatment can be administered if needed

- Even though naloxone is a prescription-only medicine, with the right training anybody can use it "for the purpose of saving a life in an emergency"

- The first people to find overdosing drug users are often family members, partners and other carers (who may be drug users themselves). Research suggests many of them are willing to carry naloxone

- The 2007 UK Clinical Guidelines support the use of naloxone as a way of preventing fatal overdoses

- The NTA launched an overdose and naloxone training programme for family and carers of opiate users in 2009

- The pilots ran at 16 sites in England from July 2009 to February 2010. The NTA evaluated the results of the carers' questionnaires and talked to the pilot leads and carers who went through the training

- Details of the aims of the programme, and the methodology of the evaluation, are in Appendix 1, available at www.nta.nhs.uk.

2. THE RESULTS

- At 16 pilot sites around England, 495 carers were trained to respond to an overdose using basic life support techniques. Those at 15 sites were also trained to administer naloxone

- Following the training, and as of the date of this report, there have been 18 overdoses where carers used naloxone and two where they applied basic life support. All the drug users survived the overdose. Most of the incidents were 'opportunistic' interventions, where the carer used naloxone on somebody other than the person named on the prescription

- It was more difficult to recruit carers for training than expected, but sites remained committed to running the training. Every site was able to train some carers

- Pilot leads and carers both felt it made sense to train those people most likely to be present when users were taking drugs and running the risk of an overdose – often family members, but also other users. Several sites trained pairs of mutual carers (partners, close friends, or housemates), who both received a naloxone supply. Some were former service users no longer at risk of overdose themselves, but who cared for somebody at risk

- For many, the training clarified the causes of overdose and dispelled myths about how to respond to an overdose. Several said that even if they forgot all else, they would remember how to use the naloxone

- Parents said the training increased their knowledge around overdose, as well as feelings of empowerment and confidence. They felt that they now had a measure of control over their son or daughter's drug use by being able to intervene in an overdose – whereas previously they had felt powerless. They said the training meant they were more willing to intervene in overdoses, and less concerned about using needles and triggering withdrawal symptoms in revived users

- Carers were trained in a variety of settings. One site trained carers from Portuguese and Italian communities. To successfully recruit them, they provided interpreters, and information leaflets in those languages

- Another site targeted people who had just left inpatient detoxification, who have a high risk of overdose. The site found it difficult to engage these people, possibly because the stigma around drug use in their community (which was ethnically diverse, with a large Asian population) meant the family didn't know the user was receiving treatment – the offer of training would have revealed this

- What's more, detoxification was seen as the point beyond which the user would not take drugs again, so it was difficult to persuade users and their carers that the training was necessary. Despite this, the site worked with nine carers, showing them how the training could fit into a recovery plan for the user

- It was challenging to provide training to carers of users about to leave three different prisons. At one site, family members were reluctant to have training at the same time as visiting relatives in prison, as this took time away from the visit itself. Trainers had to change their recruitment methods to increase interest in the training. At another, needles could not be provided to prisoners prior to release because of health and safety concerns (prisons have different rules on the possession and transfer of property, including needles and syringes)

- Some prisoners and family members were concerned the training implied they were either using drugs in prison, or would again after leaving. They feared this might affect the length of their sentence or eligibility for parole. However, pilot sites successfully promoted the training as a step towards recovery upon release, and a means of encouraging relatives to keep away from drugs after release, with overdose being an unexpected but potential occurrence

- Most carers responded positively to the initial approach for training; but some sites reported that not all carers felt ready for training. Some, including a few with long histories of contact with carer support groups, found the subject too distressing to confront. Others whose adult children had overdosed (fatally and non-fatally) could clearly see naloxone's potential for saving lives. Some also said their attendance on the training course had, in part, caused the user they care for to reduce or even stop taking drugs

- Other benefits included creating better contact between service users and treatment services, and more open dialogue between users and their carers about opiate misuse

- Pilot sites found that the training worked well when provided alongside their other day-to-day drug treatment services

- All pilot leads who were interviewed said they wanted to continue training carers, subject to local funding and governance arrangements. Pilot leads recognised the value of training carers and said that if they were to do it again, they would include service users as well

- The overall conclusion is that while training carers is beneficial in itself, training service users and providing overdose training and naloxone to as many people as possible may need to be considered to achieve a wider impact on overall fatal and non-fatal overdose rates.

3. POINTS TO CONSIDER FOR FUTURE TRAINING

These notes are for organisations that want to provide overdose response and naloxone training for carers. Several points may also apply if organisations want to train service users.

There are also considerations for commissioners, who assess local need and commission appropriate interventions to prevent drug-related deaths (one of the best practice outcomes in the 2010 Drug Strategy). Providing overdose response and naloxone training is one such intervention to consider. UK clinical guidelines, along with several published studies from around the world, make clear that take-home naloxone is a viable intervention in a package of measures to prevent drug-related deaths. However, it is difficult to prove the cost-effectiveness of naloxone, a point reflected in the lack of published research on the subject.

Questions that need answering

- Do you have support from local commissioners, local medicines management, drug treatment services, drug partnership, and carer and service user organisations?

- If providing training to carers of people in prison, what are the support and follow-up arrangements with community treatment services when the prisoner is released?

- What knowledge of overdose response and naloxone do staff currently have? Will they benefit from training themselves?

- Are there qualified trainers within the organisation? Will you need to improve the skills of current trainers, or bring in external trainers?

- Do you have the capacity to set up and incorporate training into your existing service provision? Do you have a dedicated project lead or champion to ensure training has an impact?

- Do you have appropriate prescribing mechanisms – either direct prescribing to the patient, or providing naloxone using a Patient Group Direction (PGD) or Patient Specific Direction (PSD) with an appropriate informed consent process?

- Have you checked there are no reported or expected naloxone shortages, and do you have contingency measures in case shortages do occur?

What is the definition of a carer?

"[A] family member is defined as any adult person who is significant in the life of the drug user, irrespective of his or her biological, social or legal status. A carer is defined as anyone who cares for or offers support on a regular and personal basis to an individual, whether or not he or she has formal carer responsibilities and status."

Carers may include family members (parent, partner, sibling, son or daughter), housemates and close friends. These people may be former or current heroin users themselves. It is appropriate to train those most likely to be with an opiate user at the time of an overdose (that is, when they are using drugs).

Dedicated resources

Many sites said that having a dedicated programme lead for the pilot helped enormously, whether they worked solely on the pilot or had additional work commitments. Some sites that didn't appoint a programme lead said their day-to-day work suffered, especially if they had little experience of training carers or service users. Most sites said they had underestimated, to a degree, the time and effort required to set up a training programme.

One site said it helped to have champions at three strategic levels (consultant, managerial/staff, and service user). This meant the training was promoted effectively, and that any issues could be quickly addressed.

Gaining local support and securing naloxone supplies

Several sites said the key to success was getting approval from partner agencies, commissioners, local drug partnerships and primary care trusts (PCTs), and medicines management committees before training started. Some said the NTA's endorsement and funding had helped to secure support from local stakeholders at the beginning and throughout the programme.

To take part in the NTA programme, sites had to show they had clinical leadership and competence in naloxone prescribing and overdose training. They also needed the backing of the local PCT, and specifically the pharmacy lead. Most sites implemented a PGD or PSD, which provided naloxone, usually via a non-medical prescriber (NMP), in lieu of prescriptions. These arrangements were helped by support from medicines management committees. One site did not have this buy-in at an early stage and found it could not provide naloxone because of concerns about follow-up and aftercare.

Local areas planning future training may find it helpful to check there are no reported or expected naloxone shortages, and to have contingency measures in case shortages do occur. Supplies also need to be replaced once they expire (naloxone has a shelf life of two or three years) or are used. Sites sourced supplies from within the organisation providing the training, or from local hospitals or pharmacies.

Supplying naloxone

- Naloxone is a prescription-only medicine in England, although it may be used by anyone for the purpose of saving life in an emergency

- It can be prescribed directly to a patient, or given via a PGD or PSD

- Prescribers should only prescribe and supply naloxone to a known patient with a medical condition that requires the medication, and with the patient's informed consent

- This means naloxone cannot currently be prescribed (or supplied using a PGD/PSD) to a carer on behalf of a drug user, and cannot be given to a carer without the drug user's informed consent.

- The sites therefore had to fulfil three requirements before they could supply the drug:

1. The naloxone should be prescribed for a specific patient (or supplied by PGD/PSD) to an opiate user only
2. This prescription should therefore be provided only with the opiate user's informed consent
3. The opiate user needs to give written or verbal consent if a carer is to collect the naloxone on his or her behalf.

Four common approaches to supplying naloxone, using illustrative scenarios of what happened during the pilots, are included in Appendix 2.

Training staff

Most sites also trained their staff. This ranged from 'training the trainers' to one service training all their workers to use naloxone. As well as improving the skills of staff, this meant they could also promote the pilot during their day-to-day work. Several service users said they first heard about the training from a keyworker while visiting the service on another matter.

Several pilot leads said awareness of harm reduction and overdoses had improved among their staff, and that attitudes to the training had changed over time – at one site where a trainee used naloxone to reverse an overdose, staff became more supportive of the pilot and the demand for training went up.

For some sites, the principles of harm reduction were already embedded among staff, but running the pilot added to their knowledge and training.

Recruiting carers

Pilot leads said promoting the training took a lot of effort. To begin with, attendance at some sessions was poor. A number of people found they couldn't attend, or changed their minds. Pilot leads and trainers believed this reflected the often chaotic lifestyles of opiate users and the demanding job of caring for them. Much of the training also coincided with poor winter weather, which hit attendances hard.

Sites promoted the training with leaflets and posters, speaking at regional forums and meetings, and

information sessions for staff. Several carers (and users) in the focus groups said they got involved in training via their own keyworkers, or the keyworkers of the people they cared for. Some pilot leads attended local harm reduction and commissioning groups to promote the training. Others spoke to the police about what naloxone was and how it worked, should the police find it on someone and mistake it for an illicit drug.

Some sites incentivised carers – for example, by paying travel costs. Others had good uptake without having to use such measures. Some felt incentives were inappropriate, and that the incentive to potentially save a life was sufficient.

What might a training session include?

At a minimum, it will be important to cover:

a. Overdose and naloxone knowledge

At the end of the training session, carers will:
– Understand the causes of opiate overdose
– Know how to recognise overdoses and respiratory arrest
– Know what action to take in the event of an overdose
– Know what naloxone is and how it is used
– Have had myths and misconceptions about overdose and its treatment dispelled
– Have practised some basic first aid techniques
– Feel more confident in dealing with an overdose.

b. Managing an overdose

At the end of the training session, carers:
– Will know what to do if they see an overdose
– Are confident they can respond appropriately, including:
  Phoning 999 and asking for an ambulance
  Performing rescue breathing if needed
  Putting someone in the recovery position
  Knowing when to use naloxone.

c. Giving naloxone

At the end of the training session, carers know:
– Where to keep naloxone
– How to prepare a naloxone injection
– How and where to give naloxone
– How much naloxone to give and when to give another dose
– What to do when the user comes around, and what to do if they don't.

In addition

- To attract carers and make it easy for them to attend, provide training at a convenient time and location – ask for their views
- Training carers in small groups, one-to-one, or in their homes, may be appropriate
- Depending on who attends, adapt the content and length of the training session. For example:
  – Are they family-member carers who are unfamiliar with using needles, or who may benefit from a longer session (for example, two hours) that includes drugs awareness training?
  – Are they carers who formerly used or currently use drugs, and may have experience of overdoses, but who might need longer to address overdose myths?
  – Carers who formerly used or currently use drugs may benefit from shorter training sessions (e.g. an hour or under) that cover the basics of naloxone and advice on phoning an ambulance
  – If the carers are not known to the organisation, a brief survey of their knowledge of drugs and/or overdose and naloxone will indicate what level to pitch the training
  – Sticking to agreed time limits will help carers who have limited availability, such as those in full-time employment
  – On the other hand, allowing sessions to overrun can help in certain situations, for example, when the content has been distressing for some carers and they need extra time for discussion either one-to-one or within the group
  – It may be useful to enhance the content of the training session to include more advanced first aid techniques such as CPR.

Follow up

Carers felt that contact should be maintained after training, and that refresher training should be provided around every six months. They said this ought to consist of a shortened version of the full training, but include any updates to basic life support techniques. Some also said they found it difficult to obtain new supplies of naloxone after they had used or misplaced their original supply.

For some, sharing their feelings since completing the training was an important process, as was hearing accounts of those who had used naloxone – they found this empowering, and it gave them extra assurance that the training worked in the 'real world'.

Some sites did contact carers afterwards as part of the training package, but none planned to offer refresher training. Carers who received materials showing them how to provide basic life support and give naloxone (such as the Harm Reduction Works DVD, 'Overdose and naloxone') said that these helped them remember the training.

Follow-up contact with carers can ensure local clinical protocols are met, such as providing support in case a fatal or non-fatal overdose occurs, and if naloxone is used. This contact can also be a crucial opportunity to provide refresher training and resupply naloxone. Carers may also welcome the opportunity to 'debrief' with a trainer or staff member if the naloxone is used. Carers and the people they care for can find it beneficial to share experiences in a group environment after training.

More information

The appendices for this report are available at www.nta.nhs.uk. They are:

1. Aims and methodology
2. Guidance notes for naloxone supply
3. Questionnaire A – carers' experience and demographics
4. Questionnaire B – ability, willingness, and concerns
5. Carers' focus group questions
6. Pilot leads and trainers interview questions
7. List of pilot sites
8. Links and further reading.