



Research paper

'I have it just in case' – Naloxone access and changes in opioid use behaviours



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ARTICLE INFO

Article history:

Received 5 March 2017

Received in revised form 29 June 2017

Accepted 11 September 2017

Available online xxx

Keywords:

Opioids

Opioid overdose

Naloxone access

Opioid use behaviours

ABSTRACT

Background: The past decade has seen over a four-fold increase in deaths from opioid overdose in the United States. To address this growing epidemic, many localities initiated policies to expand access to naloxone (a drug that reverses the effects of opioids); however, little is known how naloxone access affects opioid use behaviours.

Methods: The present qualitative study used semi-structured, in-depth interviews with inpatients at a substance use treatment centre. All patients who met study inclusion criteria (in treatment for opioid use, between the ages of 18 and 40, able to speak and understand English, and had not previously completed an interview with the research team) were invited to participate. Interviews were conducted until thematic saturation was reached (N = 20) and covered the participant's naloxone knowledge, access, and attitudes, as well as experience(s) with opioid use and opioid overdose, and their naloxone use in the context of opioid overdose. Thematic content analysis was used to analyze interview transcripts.

Results: Five main themes were uncovered during analysis; first, awareness about naloxone, including, content knowledge and source information for naloxone. Naloxone awareness was very common among opioid users; however, depth of knowledge varied; some participants did not make any efforts to have naloxone available, and others felt that it was "just as important as a clean needle." The second theme explored how naloxone access intersects with drug selling. The third theme explored naloxone availability while using, including attitudes about naloxone, occasions with no naloxone availability, when naloxone is "good to have," and when naloxone is a priority for users. The fourth theme examined changes in opioid use behaviours associated with naloxone access. Primarily, participants discussed changing how much heroin they used in a given situation to achieve a bigger high. The final theme explored naloxone behaviours that alter overdose mortality risk, such as how users distinguish when to use naloxone, dis-incentives to naloxone use, and solo opioid use.

Conclusion: Results indicate that though naloxone awareness was high, there was great variation in the associated attitudes and practices. Participants generally described naloxone as an important resource, but not all were inclined to carry or use it appropriately. Future research needs to examine why different groups of opioid users access naloxone differently, particularly to identify those at risk for experimental opioid use while carrying naloxone.

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Opioid overdose death continues to be a critical public health crisis in the United States (U.S.). In 2015 there were 33,091 deaths from opioid overdose, an increase of 15.5% from the previous year (Rudd, Seth, David, & Scholl, 2016). This trend has been increasing dramatically over the last several years; there has been a 220%

increase in opioid overdose deaths since 2002 (Rudd et al., 2016). Further, these deaths are being driven by synthetic opioids like fentanyl, in addition to heroin. From 2014 to 2015, there was a 72.2% increase in deaths from synthetic opioids other than methadone (e.g., fentanyl) and a 20.6% increase in deaths from heroin; these trends applied across all demographic groups and U. S. regions (Rudd et al., 2016).

Also of note is the global nature of opioid use and overdose; some estimates indicate that up to 39 million individuals are “problem users of opioids” (Degenhardt & Hall, 2012: p. 55). Opioid dependence accounts for 9.2 million disability-adjusted life years (SALYs), an increase of 73% from 1990 to 2010 (Degenhardt et al., 2014). A recent systematic review indicates that global lifetime prevalence for drug users experiencing a non-fatal overdose range from 16.6% to 68.0% of users; further, the population-based overdose mortality rate ranged from 0.04 to 46.6 per 100,000 person-years (Martins, Sampson, Cerda, & Galea, 2015). Diversity in region, time periods, and samples likely accounts for the wide ranges for these estimates (Martins et al., 2015). Importantly, these estimates likely under-estimate the global burden of disease associated with opioid use and overdose as rates have increased steadily between 2010 and 2015 in the United States (Rudd et al., 2016).

The increase in nonmedical opioid use has been aided by opioid prescriptions written by medical providers for specific pain conditions (Compton & Volkow, 2006; Kolodny et al., 2015). In 2012, providers wrote enough opioid medication prescriptions for each adult in the United States to receive one bottle of opioid pain pills (Centers for Disease Control and Prevention, 2014). The increased frequency and high dosing of prescription pain pills has led to opioid addiction and individuals who use opioid medications purely for the feeling they cause (Compton & Volkow, 2006; Kolodny et al., 2015). Other research has shown that prescription opioids are perceived as less dangerous than heroin among nonmedical opioid users because prescription opioids are prescribed by a physician (Daniulaityte, Falck, & Carlson, 2012). Further, pharmaceutical companies that manufacture opioids exploited the effort to treat pain as a “fifth vital sign” and supplemented doctors’ prescribing habits with aggressive marketing; Purdue Pharma even went so far as to promote their controlled-release OxyContin as safe for chronic pain and non-addictive (Meldrum, 2016; Van Zee, 2009). As a result, more Americans became addicted to prescription opioids. Many individuals began switching to heroin once opioid pills became more challenging to obtain or did not provide an adequate high (Jones, 2013; Mars, Bourgeois, Karandinos, Monteiro, & Ciccarone, 2014). The rate of heroin use has risen dramatically, as has the rate of heroin overdose (Kolodny et al., 2015; Rudd et al., 2016).

To address this growing epidemic, states initiated policies to expand naloxone (Narcan[®] ADAPT Pharma) access. Naloxone is an opioid antagonist that reverses opioid overdose; it is safe, effective, and can be administered using a syringe (intramuscularly) or intranasal atomizer (intranasally) (Boyer, 2012). Naloxone administration is time-sensitive, that is, the sooner it is administered after an overdose, the more likely it is to effectively reverse the overdose. As a result, opioid overdose prevention initiatives have targeted naloxone education and distribution programs at non-medical personnel (“lay people”), such as friends, family members, and opioid users (e.g., Wagner et al., 2010). These individuals are often the ‘best’ responders because they are at the scene of an overdose first (World Health Organization, 2014). Currently, 43 US states and the District of Columbia have expanded naloxone access to lay people (Davis & Carr, 2015), with states implementing these policies as early as 2007 (Hawk, Vaca, & D’Onofrio, 2015).

Expanded naloxone access usually occurs through opioid education and naloxone distribution (OEND) programs. OEND programs generally review signs and symptoms of overdose, how to administer naloxone, and provide each participant with a naloxone rescue kit. Naloxone rescue kits typically include two naloxone doses, a naloxone administration device (either an intranasal atomizer or syringe), gloves, and an instruction card that reviews naloxone administration procedures. Some programs target opioid users, such as those within needle exchanges, while others are open to all community members (Mueller, Walley, Calcaterra, Glanz, & Binswanger, 2015). Research indicates these are successful at increasing participants’ knowledge and ability to respond to an overdose with naloxone (Mueller et al., 2015). Further, drug users, as well as lay people, are willing to be trained and respond to an opioid overdose with naloxone (Mueller et al., 2015). However, there was also concern in a general population sample that expanding naloxone access would result in more reckless use and reduce an individual’s desire to stop using opioids (Rudski, 2016). These concerns were similar to those expressed by medical providers, particularly whether naloxone would increase current drug use, allow for riskier drug use, or provide a false sense of security to drug users (Green et al., 2013).

Currently, we do not know if these concerns are valid. There is a serious gap in knowledge around how naloxone affects opioid use behaviours and its associated health and social consequences. Our previous research suggests that ‘concerned others,’ such as family members and friends of opioid users, are accessing the OEND, but it is not permeating to the drug users themselves (Heavey, Burstein, Moore, & Homish, 2017). Further, we are unaware of any research that has examined what effects naloxone has on opioid use behaviours.

Methods

The present research

The purpose of the present study is to examine naloxone access experiences among those in treatment for opioid use. As this is largely unexplored, we used in-depth interviews to develop a preliminary understanding awareness, access, attitudes, and behaviours about naloxone among those who use opioids. In the context of this study, awareness explores what participants know about naloxone and where they obtained that knowledge from; access explores whether participants have a naloxone kit and different routes for obtaining a kit; attitudes examines what participants feel about naloxone and opioid use; and behaviours explore how participants use (or do not use) a naloxone kit. We aimed to develop themes that will add to the broader theoretical understanding of overdose and naloxone use. These findings will add to knowledge in both the United States and internationally, particularly as opioid overdose is a global issue.

Study site

The present research took place at a residential substance use treatment centre. Researchers selected this centre in order to reach those with extensive opioid use experience, based on the rationale that those with extensive experience would be the optimum sample to develop preliminary understanding of overdose and naloxone use. This specific treatment centre has the widest catchment area in the region and serves 8 counties in the Western New York State region. Each patient receives specific treatment plans upon admission that routinely include physical health, mental health, and substance use counseling. Patients live at the centre for the duration of their treatment; typical treatment duration is 21 days.

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