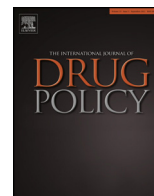




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Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

“I felt like a superhero”: The experience of responding to drug overdose among individuals trained in overdose prevention



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ARTICLE INFO

Article history:

Received 31 January 2013

Received in revised form 1 July 2013

Accepted 7 July 2013

Keywords:

Overdose

Injection drug use

Qualitative methods

ABSTRACT

Background: Overdose prevention programs (OPPs) train people who inject drugs and other community members to prevent, recognize and respond to opioid overdose. However, little is known about the experience of taking up the role of an “overdose responder” for the participants.

Methods: We present findings from qualitative interviews with 30 participants from two OPPs in Los Angeles, CA, USA from 2010 to 2011 who had responded to at least one overdose since being trained in overdose prevention and response.

Results: Being trained by an OPP and responding to overdoses had both positive and negative effects for trained “responders”. Positive effects include an increased sense of control and confidence, feelings of heroism and pride, and a recognition and appreciation of one's expertise. Negative effects include a sense of burden, regret, fear, and anger, which sometimes led to cutting social ties, but might also be mitigated by the increased empowerment associated with the positive effects.

Conclusion: Findings suggest that becoming an overdose responder can involve taking up a new social role that has positive effects, but also confers some stress that may require additional support. OPPs should provide flexible opportunities for social support to individuals making the transition to this new and critical social role. Equipping individuals with the skills, technology, and support they need to respond to drug overdose has the potential to confer both individual and community-wide benefits.

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In 2010, poisoning deaths (the majority of which are attributable to drug overdoses) were the second leading cause of unintentional death in the United States (Centers for Disease Control and Prevention, 2005). In 2010, age-adjusted death rates for drug poisoning in the US ranged from 3.4 to 28.9 per 100,000 population (Centers for Disease Control and Prevention, 2012b). Among people who inject drugs (PWID), overdose (usually related to heroin) is the leading cause of death (Sporer, 1999; Tyndall et al., 2001), even surpassing HIV-related morbidity (Tyndall et al., 2001). Community studies in the US and elsewhere estimate that

between one quarter to over half of PWIDs have ever experienced a drug overdose (Bradvik, Hulenvik, Frank, Medvedeo, & Berglund, 2007; Latkin, Hua, & Tobin, 2004; Philbin et al., 2008; Pollini, McCall, Mehta, Vlahov, & Strathdee, 2006; Seal et al., 2001; Sergeev, Karpets, Sarang, & Tikhonov, 2003; Sherman, Cheng, & Kral, 2007).

In the absence of other clinical interventions, the recommended response for bystanders witnessing an opioid overdose is to provide rescue breathing and summon emergency medical assistance. However, PWID report considerable barriers to calling emergency help, mostly centered on a fear of police involvement (Bennett, Bell, Tomedi, Hulsey, & Kral, 2011; Davidson, Ochoa, Hahn, Evans, & Moss, 2002; Lankenau et al., 2012; Tobin, Davey, & Latkin, 2005). In an effort to address the barriers that exist to seeking timely medical care and, more broadly, to respond to the growing epidemic of opioid overdose deaths, many communities have begun

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implementing overdose prevention programmes (OPPs) to train PWIDs to respond to opioid overdose (Bennett et al., 2011; Enteen et al., 2010; Galea et al., 2006; Gilbert et al., 2011; Maxwell, Bigg, Stanczykiewicz, & Carlberg-Racich, 2006; Seal et al., 2005; Strang et al., 2008; Tobin, Sherman, Beilenson, Welsh, & Latkin, 2008; Wagner et al., 2010). These programmes include instruction on how to prevent opioid overdose (e.g., by not mixing drugs, not combining opioids and alcohol, and using less after a period of abstinence) and how to respond effectively to witnessed overdoses (i.e., by safely stimulating the victim, safely calling for emergency medical services, administering rescue breathing, and administering naloxone). Naloxone (brand name Narcan) is an opioid antagonist that reverses the effects of opioids and allows the patient to resume breathing. Naloxone has no other uses, no dangerous side effects, and no effect on patients who have not used opioids (Sporer & Kral, 2007).

In the US, OPPs have historically been developed at the local level, usually implemented by not-for-profit organizations or state or local health departments (Centers for Disease Control and Prevention, 2012a). As of 2012, 188 community-based OPPs were active in 15 US states and the District of Columbia (Centers for Disease Control and Prevention, 2012a). These programmes have trained over 50,000 individuals as “overdose responders” since the first programme began in 1996 and have received reports of at least 10,171 overdose reversals using naloxone (Centers for Disease Control and Prevention, 2012a). An evaluation of a state-supported OPP in Massachusetts found that communities that implemented overdose education and naloxone distribution had significantly reduced overdose death rates compared to communities without such programs (Walley et al., 2013). At the individual level, participants in OPPs have been found to increase their knowledge about naloxone and overdose (Green, Heimer, & Grau, 2008; Wagner et al., 2010). Trained responders also report using more recommended behaviours in response to witnessed overdoses after being trained (Galea et al., 2006; Seal et al., 2005; Tobin et al., 2008; Wagner et al., 2010), though some structural and situational barriers exist to implementing some response techniques (e.g., when one’s naloxone is confiscated or lost; Lankenau et al., 2012).

Though OPPs are a relatively new intervention, they share similarities with other public health interventions that rely on training bystanders to respond to a medical emergency. Cardiopulmonary Resuscitation (CPR) training is one such intervention. CPR training is offered to bystanders who might witness an individual experiencing cardiac arrest. Like OPPs, CPR training teaches laypeople to recognize the medical crisis and to respond with appropriate pre-clinical care. CPR has been found to significantly improve the chances of survival for cardiac arrest victims (Sasson, Rogers, Dahl, & Kellermann, 2010). CPR trainings have been offered in broad community settings (Vaillancourt, Stiell, & Wells, 2008) as well in more targeted groups such as those most likely to witness cardiac arrests (e.g., family members of patients with heart disease; Dracup, Guzy, Taylor, & Barry, 1986). There has been concern that teaching CPR to family members of patients at risk for cardiac arrest might lead to deleterious psychological outcomes among the family members, such as increased depression or anxiety, or an increased sense of burden associated with the new responsibility (Dracup et al., 1986). Results from two randomized controlled trials conducted with cardiac patients and their family members found statistically non-significant trends pointing towards increased anxiety, depression, and hostility among family members trained in CPR (Dracup, Moser, Guzy, Taylor, & Marsden, 1994; Dracup, Moser, Taylor, & Guzy, 1997). Two other studies found reductions in anxiety among trained family members three months after CPR training (McLauchlan et al., 1992) and higher levels of perceived control among trained spouses one month after CPR training (Moser & Dracup, 2000).

Though they are a comparatively new type of intervention, some investigators have also examined the effects of participating in OPPs on training participants. In two qualitative studies, OPP participants report enhanced confidence and self-esteem after being trained (Maxwell et al., 2006; Sherman et al., 2008), positive psychological changes that might translate into other pro-health behaviors. In fact, two studies have found that participating in an OPP appears to be associated with reports of favorable changes in drug use behavior. For example, in a prospective study, Seal and colleagues (2005) reported a statistically significant decrease in the frequency of heroin injection among trainees over the six month study period. Wagner and colleagues (2010) found that half of the participants in an OPP reported that their drug use decreased in the three month period following the training.

Taken together, the findings from research on the effects of CPR training and OPPs suggest that participating in such trainings might have meaningful effects not only for patients in the community, but also for the trained “responders” themselves. However, a more comprehensive understanding of the psychological and social effects of being trained and subsequently responding to a medical crisis (i.e., a drug overdose) is needed. Particularly for PWIDs, who generally occupy a marginalised and stigmatised role in society, the act of taking up a new social role as an “overdose responder” could be accompanied by both positive effects that should be reinforced and negative emotions that may require additional support.

In this paper we explore the experiences of 30 PWIDs who participated in an OPP and used their new skills to respond to overdoses in their community. In this analysis we use the sociological concept of the “social role” to examine the processes through which people take up and occupy the role of “overdose responder”. Social roles, in their most basic form, refer to the ways in which people are expected to behave given their “status” in a society – for example a person might have a status of “father” with respect to one child and a status of “uncle” to another, his social role in each case is the behavior expected of him with respect to those two different children. Individuals in society take up social roles through their interactions with others, and may occupy multiple roles that are shaped by various social contexts (Lopata, 1994; Goffman, 1959). In this case, we examine the interactions amongst PWIDs, the training programs, peers, and bystanders at overdose events, with the goal of understanding the experience of becoming an overdose responder in this community.

Methods

Setting

This analysis is based upon data collected for a larger study designed to evaluate OPPs offered by two community-based syringe exchange programmes (SEPs) in Los Angeles, California, USA. The OPPs included instruction on how to prevent overdose, recognise the symptoms of an overdose, and implement appropriate response techniques including giving rescue breathing, calling for emergency medical services, and administering naloxone (Maxwell et al., 2006). Training curricula included both a didactic instructional component and a hands-on component in which participants used a CPR dummy and engaged in role-playing exercises to practice the response techniques. Participants who successfully completed the training met with a medical provider and received a small nylon bag containing two or three 1cc doses of naloxone with a prescription attached, syringes for intramuscular injection, alcohol wipes, latex gloves, a rescue breathing mask, and a small instructional card summarising the response techniques and containing programme contact information.

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