

Montgomery County Unintentional Drug Poisoning Coalition

December 6, 2010 Meeting Notes

East Dayton Health Center

Attending:

Gary LeRoy, MD; Gideon Adegbile, MD; Rick Buenaventura, MD; Robert Carlson, PhD; Gail Chmielewski, MS; Raminta Daniulaityte, PhD; Russel Falck, MA; Jim Gross, MPH; Andrea Herman, MPA; Andrea Hoff; Tim Lane, MEd; Lee Lehman, PhD, MD; Lt. Bradford Nickels; Asst. Fire Chief Jeffrey Payne; Willie Scales; Monica Sutter, RN; Doug Teller, MD.

Dr. LeRoy welcomed the coalition members to the final meeting of 2010.

Tim Lane distributed a summary of Poisoning Death Review data from the first 81 cases in 2010. He called attention to the similarities between the entire group of 81 decedents and the 66 decedents whose toxicology reports confirmed the presence of prescription opioids. The critically important contribution of the Montgomery County Coroner's Office was noted.

Dr. Daniulaityte reviewed the results of the on-line survey of first responders. Survey participation (n=72) was approximately 10% of EMS personnel in the Miami Valley, a good rate of response compared to mail surveys. Some survey highlights: 1) First responders who completed the surveys considered prescription drug overdose mortality a more significant problem than did physicians and dentists who responded to our previous survey; 2) Contrary to Montgomery County Coroner's Office data, first responders believed that heroin was the most significant contributor to unintentional overdose deaths in the Miami Valley; and 3) First responders had a negative overall opinion about the importance and potential effectiveness of naloxone distribution programs in preventing overdose deaths: (a) only 20% agreed or strongly agreed that naloxone distribution is suitable for users of pharmaceutical opioids; (b) 21% thought that training drug users to reduce overdose deaths by administering naloxone was effective or very effective; and (c) 62% disagreed or strongly disagreed that naloxone distribution a good idea. Full results of the survey will be posted on the WSU Prescription OD website.

Russel Falck gave a preliminary overview of overdose data from the Greater Dayton Area Hospital Association (GDAHA). There was an average of 58 overdose-related Emergency Department (ED) visits per month during the 01/01/07 – 06/30/10 time period. This is based on a total of 2453 cases. Demographics show that 80% of the people visiting EDs for ODs are white and 51% are women. In terms of age, 15-24yo make up 16% of the cases; 25-34 yo 20%, 35-44yo 19%; 45-54yo 20%; and 55 and older made up 21%. Data indicate sedative/tranquilizers are the most mentioned drugs (n=1200); opioids other than methadone or heroin (n=621); heroin (n=468); CNS stimulants (n=317); and methadone (n=153). When analyses are completed, the results will provide the coalition with a richer view of the drug overdose problem in Montgomery County. GDAHA has been extremely helpful in getting us the data.

Tim distributed a summary of the naloxone information that has been provided to the coalition over the last three meetings and reported on conversations with intranasal naloxone distribution programs in Boston, MA, and Wilkes County, NC. The population targeted by Boston's intranasal naloxone program consists primarily of urban IV heroin users. The program uses a long-standing needle exchange infrastructure for naloxone distribution, education, and follow-up. In Wilkes County, the population is rural, but the drug use patterns are similar to those of Montgomery

County drug overdose decedents. A significant divergence from other naloxone distribution programs is that Wilkes County has relatively few prescribers and the program is based on direct contact with prescribers. Both programs receive significant non-governmental monetary support.

Russel reported on the OARRS educational session for ED physicians, including comments by participants that supported the prescriber survey results indicating that newer physicians were more inclined to register for and use OARRS than older ones.

Russel described final preparations for the Dec 9th on-line community symposium and thanked the coalition members who will be participating as presenters.

Dr. LeRoy facilitated a discussion of the naloxone issue, with the goal of reaching consensus for a recommendation to ODH, as is required by the contract WSU has with PH-D&MC/ODH. The following was discussed:

1. The suitability of naloxone education and distribution for the population of Montgomery County residents who are in danger of experiencing fatal overdoses.

- a. Multi-drug users, with high rates of prescription opioids, and frequent exposure to sedatives, including frequent exposure to benzodiazepines along with opioids, and the few instances of uncomplicated heroin overdose.

Our poison death reviews of selected cases from 2008 and 2009, the coalition's examination of the 2010 deaths from January 1 through September 15, and preliminary overview of hospital visits for overdoses reveal drug use patterns that are significantly different from the IV heroin use that have been successfully addressed by naloxone distribution programs in other locales.

- b. Most overdose deaths occur among individuals with poor health.
While most overdose victims suffer from poor health (especially heart disease of some kind), it is unclear what impact this might have on the effectiveness of naloxone or our ability to successfully promote the use of naloxone.

- c. Relatively low incidence of overdoses that might have been prevented by family members or fellow users.

Of the 81 Montgomery County drug-related OD death cases reviewed so far in 2010, approximately 85% were judged unlikely to have been prevented by the use of an opioid antagonist. In these instances, the poisoning death review indicated that: (1) opiates were either absent or not a significant contributor to the overdose death; or (2) the decedent was alone at the time of the overdose; or (3) by-standers or family members were not in the position to notice the symptoms of overdose during the period when opioid antagonists could have been effective.

- d. Based on our survey, it appears that the majority of professionals who directly respond to overdoses in Montgomery County, and who, therefore, are in a good position to understand the possible impact of naloxone use by bystanders, have a very negative view of the propriety as well as the potential effectiveness of naloxone distribution.

First responders thought that overdose was a significant problem (more so than doctors and dentists), but they were very pessimistic about the suitability or effectiveness of a naloxone distribution program.

2. Additional information and data may help clarify the appropriateness of naloxone distribution for Montgomery County.
 - a. Examination of additional coroner cases to see if a higher percentage of cases where naloxone might help emerges.
 - b. Peer-reviewed results of current naloxone programs in Boston and North Carolina, which may be available in the coming year
 - c. Further measures to bring clarity to issue:
 - i. Ethnographic interviews with OD survivors
 - ii. Further on-line surveys (e.g., community at large, pharmacists)
 - iii. Community symposium regarding naloxone
 - iv. First responder/prescriber/pharmacist education and focus groups
3. If further examination of the county's unintentional poisoning data, interviews, surveys, and results of other naloxone programs indicates that naloxone distribution might be an effective way to reduce fatalities, we would need to address some significant barriers to establishing a naloxone distribution program in Montgomery County:
 - a. Attitudes and support of prescribers and pharmacists
 - b. Community attitudes
 - c. Infrastructure to support a naloxone distribution program. Unlike Boston (needle exchange programs) and Wilkes County (direct recruitment of the small number of prescribers), there is no obvious existing infrastructure for Montgomery County
 - d. In additional, we would have to address costs, including funding sources, likely non-governmental in nature
4. Alternatives to traditional naloxone distribution programs should also be explored:
 - a. Prescription naloxone paid for by recipient. Costs for IN naloxone is approximately \$30 for the customary 2 dose kit. Injectable naloxone is typically supplied in two syringes, at a cost of around \$2 per dose.
 - b. Pharmacy-based education for pay-as-you-go recipients via pamphlet and dvd. It would be relatively inexpensive to obtain these educational materials.
5. Considering the above, the coalition recommended forwarding a recommendation to ODH calling for deferring establishment of a naloxone distribution program until more study is completed.

Dr. Leroy thanked everyone for the time and effort they put forth during the first year of the project.

The next Coalition meeting is projected for March 2011.