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Opioids

OVERVIEW

Opioids are medicines that reduce pain, and also make people feel sleepy and calm ('sedated'), or a strong sense of happiness ('euphoria'). Opioids occur in plants and can be found in opium poppies (e.g. morphine, codeine). Opioids are also made in laboratories. For example, some are naturally occurring opioids that have been altered (e.g. heroin), while others are made from chemicals only (e.g. methadone, oxycodone, buprenorphine). The body also produces its own opioids (endorphins).

Opioids are used as a treatment for pain, but also to treat coughs and diarrhoea. The sedation and euphoria that opioids provide are the effects particularly sought after by opioid users.

Whether the opioids are legal (like oxycontin) or illegal (like heroin), misuse can lead to severe health and social problems, and a much higher chance of death at a young age. Daily or almost daily use of illegal opioids often becomes a long-term problem in which people become dependent on the drug, have withdrawals when they stop, and frequently relapse back to use after stopping. There are treatment programs (e.g. opioid substitution treatment), which can reduce the harms of illegal opioid use.

WHAT ARE SOME COMMONLY USED OPIOIDS?

- *Heroin:* is mostly injected, but sometimes smoked. It has very strong effects and is obtained illegally. Heroin is mixed with other substances such as quinine, lactose and starch to reduce its purity.
- *Oxycontin, MS Contin:* are typically injected or swallowed. They have strong effects, and last for up to 12 hours when taken by mouth. When injected the effects are stronger but shorter acting. These drugs can be prescribed by a doctor for pain relief, given by a friend or relative, or bought illegally from others.
- *Endone:* is mostly swallowed. It is shorter acting (lasting up to six hours) and has fairly strong effects. It can be prescribed by a doctor for pain relief, given by a friend or family, or bought illegally.
- *Codeine:* is mostly swallowed. It is short acting (lasting up to six hours) and has mild effects. It can be prescribed by a doctor in higher doses for pain relief (e.g. Panadeine Forte), or bought over-the-counter at pharmacies.

How common is opioid use?

About 1 in 70 Australians have ever used heroin, and between 1 in 250 and 1 in 500 people have used heroin in the past 12 months. We do not have good data on how common heroin use is among Aboriginal Australians.

Among people who have problems with illegal (illicit) opioids like heroin or street Oxycontin, it is thought that up to 1 in 7 are Aboriginal.

Around 1 in 15 Aboriginal people have ever used painkillers for non-medical reasons, and, in the past 12 months, 1 in 24 had used them. This is about two times higher than in non-Indigenous people.

Prescription opioid use has increased a lot since 2001. For example, the number of prescriptions for oxycodone (Oxycontin) grew by more than 10 times between 2001 and 2007.

People who use opioids often use other drugs as well. Drugs commonly used by opioid users include tobacco, cannabis, alcohol, methamphetamine, and benzos.

EFFECTS OF OPIOIDS ON THE BODY

Opioids act on the body by attaching to specific parts of the body called 'opioid receptors'. When opioids attach to these receptors (e.g. in the brain, in the spine, and in other parts of the body), they cause the opioid effects including pain relief, sleepiness, and a pleasant feeling. Opioids that cause strong effects at the opioid receptors (e.g. pain relief, sleepiness and a pleasant feeling) are called 'full agonists'. Morphine, heroin, codeine, methadone, and hydromorphone all have strong opioid effects and are examples of full agonists. Some opioids, like buprenorphine, cause much less opioid effect. These are called 'partial agonists', meaning they cause only a part of the opioid effects. Partial agonists cause less sleepiness and less of a pleasant feeling compared to full agonists (see Opioid receptors, p. 203).

Main effects of occasional use of opioids on the body

- Less pain
- Sleepiness (sedation) and relaxation, calming
- Strong sense of happiness (euphoria)
- Small pupils ('pinned')
- Slowed breathing
- Decreased blood pressure
- Increased sweating
- Less bowel activity.

Long-term daily use of opioids

With long-term use of opioids, there is less pain killing effects over time, less sedation, less drop in blood pressure, less slowing of breathing and less euphoria. Pupils remain small even with very long-term opioid use.

Other common side effects from long-term opioid use are:

- Constipation
- Hormonal changes which can cause reduced sexual desire and problems with sexual function (e.g. impotence in men)
- Lots of sweating
- Sleep problems.

HOW TO RECOGNISE HARMS FROM OPIOID USE

Physical harms

- Overdose: Overdose is common in opioid users. Overdose happens when the opioid dose is too strong for that person. People in overdose will have slowed breath that can stop and lead to death, and they may be sleepy or unconscious ('on the nod'). People who are newer to using opioids, or use low amounts or less often are more likely to overdose, as they have not yet adapted to using opioids (i.e. they have low tolerance). Overdose is not related to the person's size. Death from overdose can happen within minutes.

In case of overdose the following steps are vital

- Put the person in the recovery position
- Call for help – ambulance if the person has very slow breathing
- If breathing stops, clear the mouth and throat and give CPR (see p. 436)
- The antidote, Narcan, can be lifesaving.

- Harms from injecting
  - Injecting any drug can lead to infection with blood-borne viruses like hep C and hep B. HIV is not common in people who inject drugs in Australia, but can still be spread by sharing needles, syringes and other injecting equipment.
- Injuries and infections from injecting are common in people who inject opioids. This can include skin infections (e.g. cellulitis), and abscesses or infections in the blood and heart, which can lead to death (see Harms from injecting, p. 289).

Using opioids and the chance of becoming infected with hep C

Out of 10 injecting opioid users who have been injecting for four years or more, up to seven of them will become infected with hep C (see Hep C and hep B, p. 302).

- Harms from smoking: Some people think that smoking opioids reduces the chance of overdose and does not lead to dependence, but overdose and dependence can happen when smoking opioids.
- Dental problems: Taking opioids long-term can cause teeth decay as opioids dry the mouth and reduce saliva (spit). Saliva helps kill bacteria so is important in protecting teeth. Heroin, Oxycontin, methadone and most other opioids have the same effect on teeth (see Opioids and teeth, p. 204). People on methadone can reduce dental problems by cleaning their teeth regularly, seeing a dentist and chewing sugar-free gum to increase saliva flow.

Psychological harms

The main psychological harms of heroin use happen because it is illegal and there is a lot of stigma around use. When people become dependent on heroin, life becomes very complex which can lead to anxiety and depression.

Social harms

- Buying opioids, such as heroin or Oxycontin 'on the street' is expensive. People who are dependent usually need a lot of money to maintain their opioid use and avoid withdrawal (e.g. people dependent on heroin usually use between $50 and $200 worth of heroin a day).
- Because of this, the person's finances, employment, and relationships with their partner and family are often destroyed.
- People dependent on opioids may turn to crime or sex work to raise money to continue using opioids. This can lead to a loss of respect in their community, and many people end up spending time in jail.

HOW TO RECOGNISE OPIOID DEPENDENCE

When a person is dependent on opioids their drug use becomes more important for them than most other things. For example, drug use may take priority over work, relationships, finances, health, family and community.

A person can become dependent on opioids very quickly. Others may continue with occasional use for a long time. On average, people become dependent after one to two years of opioid use.

Opioid dependence is said to be present if three or more of the following have been happening (together at some time) during the previous year:

- A strong desire (craving) or need for opioids (compulsion); for example, if trying to stop or cut down
- Hard to control opioid-taking behaviour
- Physical withdrawal when opioids are stopped or reduced, or using an opioid (or other drug) to relieve or avoid withdrawal symptoms
- Needs to use more opioids just to feel its affects (tolerance; i.e. higher doses are needed to get the same effects that were originally experienced by lower doses)
- Opioids become number one in the person's life. Family, work and everything else becomes secondary. More and more time is taken up getting and using opioids.
- Keeps using opioids despite clear signs of harms. You could check that the client is aware that this harm is linked to their opioid use.

If the person returns to opioid use after a period of not using (abstinence), these features may very rapidly reappear.

A clear sign of opioid dependence is when a person goes into opioid withdrawal when they cannot obtain the drug, or when they intentionally stop using.

Opioid dependence, if severe, will often be a chronic relapsing condition. It is not unusual for people to struggle with this condition for 10 to 20 years. We know now that opioid dependence is a complex condition. People can be more at risk of becoming dependent due to their genes (make-up), early development and social supports. Once dependent, they have problems with finances, work, health, and social networks, which can make life difficult and make it harder to stop using. Also, there are changes that happen in the brains of people who are dependent that make it more difficult to stop using. This does not mean people cannot overcome opioid dependence, but stopping use can be a long-term struggle. Health workers need to be realistic about what can be achieved by dependent people at particular times.

HOW TO RECOGNISE OPIOID WITHDRAWAL

Opioid withdrawal is usually not medically dangerous. It does not cause hallucinations (seeing and hearing things that are not there) or seizures, and people do not become very confused. Opioid withdrawal usually starts within about 24 hours of the last use of short-acting opioids like heroin. Symptoms can be very unpleasant, and are similar to a bad case of the flu.

Opioid withdrawal mostly takes the following course:

Day 1 (first 24 hours): increased sweating, runny eyes, runny nose, loose bowel motions, aches and pains, sleep problems, craving for opioids.

Days 2 to 4: diarrhoea, feeling sick in the stomach (nausea) and vomiting, stomach cramps, worsening aches and pains, headache, passing urine more often, 'goose bumps', small increase in heart rate and blood pressure, anxiety, low mood, sleep problems get worse, and strong cravings for opioids.

Day 5: withdrawal symptoms fade away over the day, except for some persisting sleep problems and moodiness. Cravings can continue for a number of weeks, though they tend to slowly go away over that time.

However, if your client has been using longer-acting opioids like methadone, then withdrawal will come on more slowly, and last longer before it fades away. Methadone withdrawal can last three to four weeks for clients who have been taking methadone for many years (see Opioid substitution treatment, p. 150).

While opioid withdrawal is usually not a medically serious or dangerous condition, it can sometimes be dangerous. For example:

- In pregnant women: withdrawal can cause miscarriage, early labour, or other risks to the health of the baby or mother.
- When withdrawal is brought on suddenly by taking an opioid blocker drug like naltrexone (oral tablet) or Narcan (naloxone injection). This can cause severe vomiting and diarrhoea, and mental confusion (delirium) where clients may hallucinate and not know where they are. If this happens, clients can be at risk of harm to themselves or others.
- In people who are already very sick.

HOW TO ASSESS A CLIENT WHO USES OPIOIDS

Encouraging your client to talk about their opioid use

Clients may have many reasons why they will not talk about their opioid use. They may be:

- Worried about getting into trouble with the law
- Embarrassed or ashamed because of stigma about opioid use
- Worried you will tell people who they do not wish to know
- Worried about having their children removed if they talk about drug use.

Ask about opioid use in a non-judgmental way, using non-threatening language, so the client feels more comfortable talking to you about their use. You could say:

- "A lot of people take painkillers or use stronger drugs like heroin. They can be really tough to get off. Do you use heroin or other painkillers? Have you used them in the past?"

Finding out more about your client's opioid use

If the client says that opioid use has become more important than other aspects of their life, this is the key sign of dependence. Of course, describing withdrawals when they stop, and using to avoid going into withdrawal are also sure signs of opioid dependence. It is important to work out whether the client is likely to have withdrawals if they stop, or if they are at risk of serious problems from ongoing use if they do not stop.

In order to do this, you need to ask the client:

- Which opioids they use
- How much they are now using, how often they use, and by what route (e.g. inject, smoke, swallow)
- How long their use has been at that level
- When they first used opioids, when they started to use them regularly, and when it became daily use
- If their patterns of use have changed over the years (e.g. have they had periods off opioids, how they achieved that, and what led up to them returning to opioid use)
- When they last used, as that will help in working out if withdrawals could be an issue right now.

Talking with your client about what to do about their opioid use

Once you have found out about the client's opioid use, you should talk about what they want to do about their opioid use. If the client is undecided, take a motivational approach where you help the client think about the good and bad things about opioid use, provide information about the harms from opioid use, and what the benefits of stopping might be. This can help the client to make up their mind about what to do about their drug use.

For clients who are taking opioids for chronic pain (that is not caused by cancer or terminal illness), it is important to give information about opioids and long-term pain. There is not good evidence for the use of opioids to treat long-term pain. It seems that opioids will only reduce pain levels in up to 3 in every 10 people with chronic pain. Over time, people become tolerant to opioids (their bodies get used to them and they do not work as well) and they can get caught up wanting more and more opioids. But often all they get is more side effects and no real change to their pain levels.

If a client is interested in help, it is important to give them information about what helpful options are available, and explore any worries that they have. The client might be worried about how sick they will get in withdrawal, spending time away from their family or community, going to a detox unit, or side effects of treatment. By talking about their fears and giving accurate information, clients can become more willing to accept the help they would benefit from.

It is important to ask people who use opioids about their use of other drugs, and take their other drug use into consideration when planning how to help the person.

What you observe

Indications that people might be using opioids can also be found from observing people closely. For example:

- Look at their eyes to see if their pupils are very small, even in poor light
- Sleepiness or drooping eyelids
- Track marks on arms or needle marks running along veins are evidence of injecting drug use – a common way opioids are used.

Urine testing

Urine testing is another way to find out whether a client is using opioids, and which one(s) they are using. Sometimes it can help start a conversation about their recent drug use. Urine testing will usually show traces of opioids for 48 to 72 hours after a person has used. Long-acting opioids like methadone will be in the urine for longer. It is important to remember that a client's urine test results can be subpoenaed by courts or child protection agencies (i.e. you have to give the court or other agency the test results).

Urine test results

When looking at urine test results, the break-down products of the drug may show in the urine test. For example, heroin will show up as acetyl morphine or morphine. Morphine will show up as morphine and codeine. Codeine may show up as codeine and traces of morphine. It is best to check with labs when results are confusing, rather than jump to conclusions about the meaning of 'positive' urine tests. Also, many labs do not routinely test for some opioids including Oxycontin (oxycodone) or buprenorphine unless you ask them to.

HOW TO HELP A PERSON WHO USES OPIOIDS

The following treatments are usually available to help people who have problems with opioid use:

Detox or withdrawal treatment

As opioid withdrawal is mostly not dangerous, treatment can be provided while the client remains in the community, or can happen in an inpatient detox unit or a hospital ward.

No medicine will completely take away the withdrawal symptoms. People detoxing need to be prepared for some discomfort. The best medicine to help reduce withdrawal symptoms is buprenorphine. Clients withdrawing in the community are detoxed over about five days, where they are given a dose once a day with smaller doses each day until the dose reduces to nothing. In inpatient settings, buprenorphine is given in smaller doses throughout the day as needed to help reduce the symptoms, again with doses reduced to nothing over about five days. Buprenorphine prescribed in the community needs to come from an accredited prescriber (the doctor does a short course).

If buprenorphine is not available, clients are given medicines that target their symptoms (e.g. medicines to reduce diarrhoea, nausea, aches and pains, sleep problems, and agitation). The medicines (e.g. clonidine, Buscopan, Diazepam) are given for no more than five days so the client does not switch their dependence to these drugs.

Clonidine is a blood pressure medicine that can help reduce some of the opioid withdrawal symptoms. But this medicine can cause drops in blood pressure and pulse, so should only be used under close medical supervision (e.g. observe the person in the clinic for half an hour after their first dose).

The support of counsellors, nurses, family and friends is important to help clients to get through opioid withdrawal. It is best if support and professional help are available when a client detoxes to help them get through.

However, opioid withdrawal is often not successful in the long-term. Relapse rates back to opioid use after detox are very high (e.g. up to 9 out of 10 people may relapse within a year). Despite this, opioid withdrawal is often the necessary first step before starting a program that can provide further support. For example, to go into rehab, clients usually have to detox before entry. Clients who do an inpatient detox may be more likely to complete withdrawal and go onto to another form of treatment.

Rehab

Residential rehab programs are mostly for clients who have been opioid dependent for a long time and have suffered major life problems because of their drug use. Rehab programs require a strong commitment to making changes. Clients leave their home and family and friends for a long time, often between three months and two years. During that time they have to attend groups and counselling in the rehab, and follow the rules of the rehab. Because of this, most opioid dependent people do not decide to go into a rehab program. Also, many people drop out of rehab within the first three months (around 6 in 10 people leave within three months). On the other hand, we know that for those who stay longer, the outcomes are better (see Resi rehab, p. 58).

Opioid substitution treatment

Opioid substitution treatment (OST) is the main treatment for opioid dependence in Australia. This treatment works by providing opioid dependent people with a prescribed opioid drug that stops withdrawals and cravings for opioids, and helps clients to get their drug use and other parts of their lives under control. These treatments help to reduce the health and social problems caused by opioid dependence.

The main types of OST are:

- Methadone
- Buprenorphine (Subutex), which is buprenorphine alone
- Buprenorphine-naloxone (Suboxone), which is a combination of buprenorphine and naloxone (an opioid blocker).

> If Suboxone is injected, the naloxone can cause unpleasant withdrawal symptoms. Suboxone was designed to stop people from injecting their buprenorphine.

- Methadone and buprenorphine are long-acting medicines that need to be taken every day (or every second or third day for some people on buprenorphine).
- Methadone is a liquid that is swallowed, and buprenorphine is a tablet which is placed under the tongue. Suboxone is available as a film that looks like a small piece of plastic that dissolves under the tongue. Suboxone tablets may be phased out as they take longer to dissolve and so there may be more risk of clients diverting their dose (i.e. removing it from the dosing site before it has been absorbed).
- Because these medicines are not supposed to be injected, if taken correctly they reduce the risk of infections like hep C, hep B and HIV.

Supervised dosing of methadone or buprenorphine

Clients on methadone or buprenorphine (as Subutex or Suboxone) treatment usually have to come to a clinic or pharmacy every day or almost every day for supervised dosing. Sometimes clients on buprenorphine can have a higher dose that lasts two or even three days, so they do not have to come as often.

Clients who are stable after three months on methadone or Suboxone treatment can usually start to have some takeaway doses (where they take the medicine themselves at home). For Suboxone, stable clients can build up the number of takeaways over time, until they are receiving 30 takeaway doses at a time (picking up their medicine just once a month).

It is often difficult to access OST in rural and remote areas.

Methadone and buprenorphine are prescribed in doses that stop withdrawal symptoms and stop craving for opioids, so that if clients use opioids like heroin on top of them they do not get much of an extra effect. The actual dose to help someone become stable will be different for each client. The key is not the actual dose, but how it is affecting the client. An effective dose will stop the client from using other opioids, is not so large that it is sedating, and is not too small that the client experiences withdrawal symptoms before their next dose. An effective dose will also help the client function better in the community. Usually an effective dose of methadone will be somewhere between 60 and 120mg daily, and an effective dose of buprenorphine will be between 12 and 24mg. We know that you need a high enough dose to do well in treatment, as low doses are a common reason for treatment to fail.

OST also brings opioid dependent people into contact with doctors who can treat other physical or mental health conditions they have. It also brings clients into contact with counsellors or caseworkers who can help them sort out issues with drug use and in other areas of their lives.

Some clients may do better on methadone, while others do better on buprenorphine. There is no clear way to work out which treatment is better for different clients. Methadone may have lower rates of treatment drop-out. On the other hand, buprenorphine is less likely to cause dangerous overdose in the early part of treatment.

How long does treatment last?

Clients typically do better the longer they stay on treatment. Because of this, people are not reduced off their program if they are not ready to stop, unless their behaviour is unacceptable (e.g. aggression) or they are clearly not benefitting from treatment (e.g. using other drugs like alcohol and benzos in a dangerous way). If a client continues to use heroin while on OST they need a medical review to see if their dose is high enough.

How long treatment lasts for each client will vary. Clients who have been using heroin for many years may need several years of treatment. When a client reduces off methadone or buprenorphine, it needs to be done slowly (several months for methadone). Clients on OST have a better chance of doing well after they stop treatment if they reduce off their medicine at a time when both they and their case worker/prescriber agree that they are ready. Relapse back to opioid use is very common after stopping OST – around 8 in 10 clients relapse within 12 months of stopping the program. Sometimes people relapse because they have come off treatment too soon, or tried to come off too quickly.

What are some day-to-day problems clients have with treatment?

OST can also be difficult for clients, which can often make clients feel their life would be better without OST. For example:

- Family, friends or others may have negative attitudes about a person being on OST.
- Treatment can be expensive. Often pharmacies or private clinics will charge clients between $5 and $8 per day. Then there is the cost of seeing the prescriber regularly, which may be an issue if the doctor does not work in a public clinic or does not bulk bill.
- Being on OST means that organising trips and holidays can be difficult. There may be no dosing for the client where they want to go, and it will always need to be organised in advance.

Gaining and keeping a job can be hard when a client is on OST if they are dosing daily or almost daily at a clinic or at a time or place that does not suit their work.

People for whom access to an OST is a priority

There are some groups of people who can get on OST more quickly. These are:

- Aboriginal and Torres Strait Islander people: you should advise your client to mention that they are Indigenous as this may help them get on a program more quickly.
- Pregnant women who are opioid dependent, and their opioid using partners: this is because of the risk of complications from opioid use during pregnancy. Methadone is the treatment of choice for opioid-dependent pregnant women, as it is important to avoid opioid withdrawal because of the problems this can cause during pregnancy (e.g. early labour, miscarriage, death of the baby in the womb, womb infections).
- People with HIV and their opioid using partners: people with HIV who continue to inject opioids can place other people at risk of becoming infected with HIV through sharing of needles, syringes and other injecting equipment. Also, people with HIV with problem opioid use have trouble sticking to their HIV treatment and their health suffers.
- People with life-threatening problems from injecting opioids such as heart infections (infective endocarditis).
- Other priority groups are people with hep B, leaving jail or on court diversion programs.

If you do not know where to find a local methadone or buprenorphine prescriber, try calling any local drug and alcohol unit or the Alcohol and Drug Information Service (ADIS) in your state or territory (see p. 435).

Naltrexone

Naltrexone is an opioid blocking drug that is taken in tablet form. It has no opioid effects itself. If taken as prescribed, which is usually one tablet a day, it will block the effects of opioids for 48 hours. This means that if the person uses opioids while naltrexone is in their body, the opioids will have no effect. This sounds like a good treatment, but many clients do not take naltrexone as prescribed, and after three months only about 1 in 16 people who started treatment will still be taking it. Because of this, naltrexone is not subsidised on the PBS for the treatment of opioid dependence, so people have to pay around $140 or more per month. If a person plans to start naltrexone treatment, they have to be sure they have all opioids out of their system to avoid a severe withdrawal ('precipitated withdrawal').

Naltrexone and naloxone (Narcan, another opioid blocking drug) are used for rapid opioid detox. These drugs are given under medical supervision to a client who is opioid dependent, so that they go into severe opioid withdrawal. This is much more severe than the usual opioid withdrawal but shorter in duration. This treatment can be dangerous if not done under proper medical supervision. Even with medical supervision there are risks. Rapid detox can help people to get onto naltrexone more quickly. But the problem remains that people do not keep taking the naltrexone and usually relapse to opioid use.

There is research being conducted into forms of naltrexone that can be inserted under the skin as implants, which releases naltrexone for many months, or given as injections that work for about one month. While these are promising ideas, the treatments are still being tested and are not available in Australia at this time.

Counselling

People who use opioids, but are not dependent on them, can benefit from counselling where they learn about the risks of using these drugs. They can also learn about ways to avoid becoming dependent. This includes skills on how to refuse drugs, how to cope with urges to use, how to avoid situations where using is more likely, and how to seek help if they are slipping into dependent use.

A motivational interviewing approach can assist people to make their own decision to get help if undecided. CBT (cognitive behavioural therapy) involves helping a client to change the thinking that leads them to drug use.

For people who are dependent, counselling can help people find out about treatments that work, and how to access those treatments.

Relapse prevention counselling after withdrawal from opioids can assist to reduce the risk of returning to opioid use. As noted above, severe opioid dependence is a chronic relapsing condition, so even with counselling relapse rates are very high (see Counselling, p. 27).

Mutual support groups

Mutual support groups are meetings where people share stories of how their lives have been affected by drug use to support each other to stay 'clean'. Many people have found them helpful in maintaining abstinence from opioids. Some people do not choose these options if they do not feel comfortable talking in front of a group. Also, some Narcotics Anonymous (NA) groups do not support people staying on methadone or buprenorphine treatment and this may upset some clients (see Mutual support groups, p. 54).

OPIOID OVERDOSE

Overdose on opioids is life threatening, and may need urgent cardiopulmonary resuscitation (CPR) and medical attention. The risk of overdose is greater when opioids are taken with other depressants like alcohol and benzos (e.g. Diazepam, Rivotril, Xanax, Serepax).

Overdose is also more common when people use opioids after a period of being off them. In this situation, their body is no longer used to the effects of opioids, and a dose which may not have been dangerous when they were using regularly can all of a sudden be life threatening (i.e. their tolerance has gone down). This can happen after people are released from jail, after leaving detox or rehab, or after stopping naltrexone.

Recognising overdose

When someone is in opioid overdose, here are the signs you will see:

- The client will look very 'drugged', unsteady on their feet, drowsy and then can be seen to be 'nodding off'.
- Snoring can be heard sometimes, and this does not mean they are okay.
- Breathing becomes slowed and sometimes laboured. Breathing can stop, as can their heart.
- Heartbeat can become slow and blood pressure may drop quite low.
- The client may be confused and clouded in their thinking.
- The pupils in their eyes will be very small (pinpoint pupils).
- They may become unable to be woken up (unrousable).
- Lips and fingernails may turn blue. Their skin may become very pale and clammy.

What to do about overdose

If you are with a client who has signs of overdose, you should do the following:

> ! Call *000* for an ambulance, and try to describe to the operator what you know about what the person has taken, and what condition they are in.

- Call for help from people nearby.
- If the client looks like they are about to vomit, lie them on their side and try to make sure they do not inhale the vomit.
- Do not let the person fall asleep – keep them moving and awake if possible.
- Do not give drinks or other drugs to 'wake them up' like coffee, water, or stimulants.
- Start CPR if they stop breathing, and make sure an ambulance is coming urgently (see p. 436).
- Note: Narcan only lasts for half an hour, but overdose can last much longer.

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

There will be some clients you see who continue to use opioids even though they are experiencing problems, and others who wish to stop but cannot. For these clients, it is important to provide information to reduce the harms from opioid use. This includes information about:

- Needle and Syringe Programs and where to find one (see NSPs, p. 298)
- Safer injecting, including using clean needles and syringes and other injecting equipment, and not sharing any injecting equipment with another person. This can help reduce the spread of diseases like hep C, hep B and HIV (see Safer injecting, p. 296).
- Testing the strength of the opioid, by first using a small amount to make sure they do not overdose
- Avoiding combining opioids with other depressants (benzos and alcohol). These can increase the risk of overdose.
- The risks of driving (and operating machinery) when using drugs. People who misuse opioids have more car accidents and other injuries. Driving should be avoided by people who are intoxicated with opioids. Note: it is okay to drive on prescribed methadone or buprenorphine if the person does not feel drowsy.

- The risks of using drugs when there are children around. For example, you should talk to your client about whether they have trouble caring for their children when they are intoxicated. Also talk to your client about avoiding sleeping in a bed with babies when they are intoxicated.
- Unsafe sex that can happen after using drugs, which may lead to unplanned pregnancies and STIs.

PREVENTING OPIOID USE FROM EVER STARTING

Reducing the supply of opioids and reducing demand for opioids can help prevent problems with opioid use.

Reducing supply

Reducing supply means making opioids less available. For drugs like opioids this can be done by reducing the amount of opium poppies that are grown, and reducing the amount of opioids that are illegally brought into Australia. There is debate over how effective these approaches are, and how costly they are.

In recent years, the use of prescription opioids has increased (e.g. Oxycontin, Endone and morphine), which also increases the number of people who have problems with their use of these drugs. There are a number of ways to prevent problems from prescription opioid use, including:

- Making it harder to get a prescription. This means that doctors have to show authorities that clients really need the opioids.
- Educating doctors about the overuse of opioids
- Letting clients know that opioids do not always work well for long-term pain except in people with cancer.

Reducing demand

A number of things make a person more likely to become dependent on opioids. These include: growing up in a disadvantaged family environment, family problems, lack of supervision and discipline, and drug and alcohol use by parents and siblings. Also, earlier use of drugs and alcohol, being impulsive while growing up, and having drug-using peers also increase the chance of starting opioid use.

Reducing these risk factors may prevent opioid use problems developing in some people. Also, making young people stronger (more resilient) through programs that increase self-confidence and provide skills to live without drugs may also help prevent opioid use from starting.

FURTHER READING

NSW Health (2006). *New South Wales Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence.* North Sydney: Mental Health and Drug & Alcohol Office, NSW Department of Health. Available from: www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_019.pdf.

Access All Areas: Making treatment transparent. This series of short videos provides information about treatment for people who inject drugs. There is a list of video topics and links to view these on YouTube. See www.anex.org.au/new/publications/reports.

The National Drug Strategy has separate guidelines for the use of methadone and buprenorphine, and other publications. You can find these by googling for *national drug strategy publications*, then choosing *illicit drugs*. Or use this link:

www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/resources-menu