The Importance of Documentation in Naloxone Programming

Since naloxone provision is still largely through emergency services and medical settings, there is limited evidence showing the benefits of naloxone distribution through peer or community provision. Documenting the effectiveness of naloxone administration by laypeople (i.e. drug users, outreach workers and peer educators, and families and loved ones of drug users) is a critical component of any naloxone program and is an important tool for advocacy to increase support from community and policymakers.

The "Overdose Baseline Questionnaire" and "Naloxone Refill Questionnaire" attached are two examples of the types of documentation your program could consider. The measures collected at baseline can then be compared with those at follow-up to highlight changes in how individuals respond to overdose and hopefully show that naloxone provision to laypeople works.

Here are some reasons for gathering information before giving people naloxone for the first time (baseline), and then again when providing more (refill):

Documentation as education

When we ask these questions we discover opportunities to counsel people on harm reduction techniques. The idea isn't to just go through the questions robotically, but instead to offer guidance or answer questions that come up. For example, if someone says that they usually use drugs alone, you can reinforce in the subsequent training that it's safest to inject drugs with other trusted friends around who can help in case something bad happens. There are many potential opportunities like this throughout the questionnaires.

Documentation to improve service delivery

The answers to the questionnaires might surprise you, and may end up informing the services you provide. For example, you might find out new information about drug using practices or risks. Or you might realize that drug users are struggling with unmet needs after experiencing an overdose, and decide to start a survivor's support group. Prisoners are also provided with supplies they will need after release, such as clothes and a cellphone SIM card.

Documentation as advocacy:

Documentation helps make the case for increased funding and supportive policies for naloxone distribution to laypeople. The information collected in these questionnaires can later be used for advocacy or in journal articles, to convince others of the program's success. Another reason to collect this information is to have well-kept records that could later be used to show the lifesaving nature of your program.

We have tried to make these questionnaires as short as possible, while still including key questions. Ultimately, it is up to you to decide which questions are most relevant to your context, or if there are others you need to add. The important thing is to collect information so that you can support your participants, improve your services, defend your programs, and advocate for support for naloxone and overdose programming in the future.

*Please also remember to ensure the confidentiality of your participants.

Baseline Questionnaire

The baseline questionnaire should be conducted before the participant goes through an overdose training, and before they receive their dose(s) of naloxone. It provides an opportunity to learn more about drug using practices and current responses to overdose in your community.

Questions 1-4 collect basic demographic information about who is coming in for naloxone. For example, if you notice that few women are coming in, you may want to develop strategies to better reach female drug users, like reaching out to female sex worker groups or to the sexual partners of male drug users.

Question 5 elicits information about current drug-using trends, in order to inform your programming. For example, if people are mixing opiates with other drugs, you should spend more time talking about the associated risks during your trainings.

Question 6 is to find out where people are using drugs, so that you can target services toward these venues or so-called 'hotspots'. For example, if many people are using drugs in shooting galleries*, you may want to provide an overdose training to the people running the shooting gallery.

*Shooting gallery: a place, as an apartment, where a narcotics addict can prepare and inject an illicit drug, as heroin, with equipment usually provided on the premises

Questions 8-15 collect information about the current extent of overdose in your community, and the responses people used before being trained. This will provide you with a baseline measure of overdose incidences and practices used to respond to overdose. After training and provision of naloxone, the data collected from the refill questionnaire may show that overdose response practices improved compared to baseline. Questions about utilizing or accessing professional medical care, like ambulances and hospitals, are asked because if people are unlikely to access such services, it helps prove that drug users should have the antidote (naloxone) to prevent death. For those participants that respond that they didn't use professional services, ask them why, to document potential access barriers, like fear of police involvement, and to work with authorities to improve the situation.

Questions 16 helps inform your service delivery. It can tell you if you should distribute more informational materials, do a workshop with families of drug users, or encourage outreach workers to talk about naloxone more.

Questions 17-19 are called "self-efficacy* questions." They are asked in both the baseline and the refill, and the idea is to show that, at any point in time (the week of March 1, 2013, for example) people who are coming in for refills have higher self-efficacy than those at baseline. Programs that successfully using naloxone to reverse an overdose has a positive impact on self-efficacy, and may encourage people to seek to improve their health and the health of others in a broader sense. Once they reverse an overdose, they feel empowered to teach others how to prevent overdose, or take better care of their veins, or get tested for HIV, or take part in other services offered by the program. This could help convince other funders to support overdose programming.

* Self-efficacy is commonly defined as the belief in one's capabilities to achieve a goal or an outcome. It underlies basic self-esteem and confidence and can be an indirect measure of empowerment.

Question 6 is to find out where people are using drugs, so that you can target services toward these venues or so-called 'hotspots'. For example, if many people are using drugs in shooting galleries , you may want to provide an overdose training to the people running the shooting gallery.

Refill Questionnaire

This questionnaire is given to anyone who has received a dose of naloxone in the past, and who comes in for a refill—whether because their naloxone has been lost, stolen, sold, broken, confiscated, or used in an actual overdose situation. After administering the questionnaire, you should provide a brief refresher training on overdose response with naloxone before supplying them with a new dose of naloxone. The refill questionnaire is also important, because we hope that correct responses to overdose and self-efficacy will be higher than baseline measures.

Questions 1 and 2 collect basic demographic information about participants.

Question 3 is asked because we want to show that naloxone can be successfully used by anyone—even those with limited education.

Question 4 is important to track how the naloxone have been used, and how many times naloxone has been used.

Questions 5 a-h collects basic information about the overdose incident during which the naloxone was used. 5a asks the relationship of the respondent to the person who overdosed. Besides providing that data, it will help you support the person answering the questions: if it was the person themselves or their spouse or family member, you may need to provide them with more support than if it was a stranger that they helped. Either way, being present during an overdose can be a life-altering situation, and you should be prepared to allow the participant to talk about their experiences, and listen in a supportive way. It can also be a key opportunity to connect people to other services. 5b and 5c help collect data about the age and gender of those in your community experiencing overdose. 5d asks which drugs were being used, which will help you tailor your trainings. 5e and 5f will inform you if there are specific locations where you should target your outreach efforts. 5g asks who else was around the person who overdosed. It may tell you that you want to do more trainings for family members or sexual partners of drug users, for example.

6a and 6b ask about recent release from prison, jail, or detention center, because we know that these are times of higher overdose risk. People are at greater risk for overdose after experiencing a period of abstinence. Therefore, it is important to include questions that capture the various experiences that may result in this (i.e. detoxification or rehabilitation services, etc). These statistics can be helpful in advocating for pre-release overdose training and naloxone provision.

Question 7 collects information about how people responded to overdose. If they've responded incorrectly, gently correct this during your refresher training and explain why some methods may not be appropriate, and be sure to applaud them for their efforts to help.

Questions 8a and 8b seek to find out how people are administering naloxone. If muscle syringes are available, the best way is to inject it straight into the upper arm, thigh, or butt muscle. But if only IV syringes are available, it may be difficult to inject into the muscle. Finding out how people are injecting the naloxone can help improve the supplies provided.

Questions 9a-9d seek to find out how much naloxone is needed in peer response. We think that people may require more naloxone in an unfamiliar and stressful environment like a hospital, than in a comfortable and familiar environment with peer support. This question hopes to gather information about how much naloxone is necessary on the street. In question 9d, if people are leaving victims alone rather than staying to make sure their overdoses do not return, you may want to stress the importance of keeping an eye on the victim for the next couple hours or you may want to find out why people are leaving so quickly.

Question 10 collects information about "adverse events." Withdrawal symptoms are normal, but seizures and pulmonary edema* should be extremely rare events, if seen at all. We collect this information in order to provide proof that naloxone is safe, in case people challenge us. The other symptoms listed—depression, guilt, anxiety, negative emotions, or legal and financial problems—can be common after experiencing an overdose. You may want to start projects to address these, like an overdose survivors support group.

*Pulmonary edema is fluid accumulation in the lungs which can lead to shortness of breath. Symptoms include difficulty breathing, anxiety, pale skin, coughing up blood, among others.

Questions 11 may help inform your programs. If people aren't being taken to the hospital, you might want to do a focus group to find out why. Is it because people are confident naloxone worked? Or are they wary of going to the hospital because they don't want to be identified to authorities or incur medical bills?

Question 12 helps collect data about the number of successful overdose reversals using naloxone. This can help show that peer and community-based naloxone programs are successful and should be continued and scaled up.

Questions 13, 14, and 15 are self-efficacy questions. As explained above, we hope to show higher self-efficacy scores through the refill questionnaires than at baseline.