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The Administration of Naloxone: Social Care Worker Perspectives and Experiences

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Introduction

Opioid addiction in many countries has risen considerably in recent years, leading to the increasing use of terms such as the Opioid Crisis and the Opioid Epidemic [1]. Substantial international attention has focused on this issue following significant increases in opioid related overdoses resulting in death [1-2]. This phenomenon has been particularly marked in countries such as the USA and the UK [3]. It is estimated that in 2015 Europe experienced 8,441 deaths from opioid overdose [2]. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) notes that Ireland has also experienced a significant rise in opioid and methadone related deaths in recent years [2]. Evidence suggests that on average heroin users will overdose three times in their lifetime [4], and that one in two heroin addicts will die from an overdose [5].

Health promotion responses to opioid addiction have traditionally included a range of services including health education and counselling. However, a harm reduction approach is increasingly the norm in many countries, including Ireland. Although the harm reduction approach, which is based on a utilitarian philosophy, has been severely critiqued in some more traditional circles, it is not unusual for services working with populations experiencing opioid addiction to offer services such as: provision of sterile needles/ needle exchange, alcohol swabs, vials of sterile water, education on safer injection practices; low threshold accommodation; safe injecting rooms; methadone maintenance treatment [1].

A relatively recent development in the suite of harm reduction interventions utilized in many countries is the more widespread provision of Naloxone [5-7]. Naloxone is an opioid antagonist used to counter the effects of opioid overdose. Naloxone may be administered via needle or via a nasal dispenser. Although Naloxone has traditionally been used by health professionals in hospital and first responder contexts, training in the use of this drug had widened in recent years to include opioid users themselves and their families [8-9], as well as non-health professional staff employed in drug and homeless services [10-11]. There is now considerable evidence supporting the efficacy of naloxone administration by non-health/medical professionals [8-11]. A number of pilot projects examining the administration of Naloxone via needle have conducted successfully in Ireland [10-11].

It should be noted that Naloxone administration is not without its limitations. It is for example of no use in situations of non-opioid overdose. Additionally, unless an addict is discovered soon after an overdose, it is of no use in cases where opioid use occurs alone. It has also been suggested that administration of Naloxone may also lead to people feeling that there is no need to call an ambulance, while some have suggested that it may encourage heavy opioid use or condone opioid use [12]. A number of crucial barriers have also been identified to the implementation of a successful Naloxone program. These are the absence of a coherent strategy, variations in local policy, queries over legislative support, and reluctant support from clinicians and workers [12-13].

To date little research has examined the impact on Social Care Workers of having to administer Naloxone or of witnessing it being administered [10-11]. Social Care Workers are a newly emerging discipline in Ireland, in the process of being covered by CORU, the Health and Social Care Professionals Council tasked with regulation by the Government in Ireland. Although Social Care Workers routinely study topics such as health, well-being, and health promotion [14], their training is based on a social rather than a health/medical perspective, focussing largely building a therapeutic relationship with clients while working in their 'life space'. Social Care Workers aim to support individuals and groups with identified needs link to wider services and move towards more autonomy and independence. Social Care Work is routinely a full-time front line role working with some of the most deprived and marginalised members of society, and as such staff stress and burn-out are important considerations in this field [10-11].

Method

A purposive sample of six Social Care Workers employed in a low-threshold homeless service in a provincial Irish city were interviewed. The organization operates a harm reduction policy and works with individuals who are socially excluded, and often barred from other services. The organization works with those who are engaged in drug misuse and alcohol, and are often victims of physical and sexual violence. Clients routinely have mental health issues and often exhibit challenging behaviour. The organization accepts clients as they are and does not put barriers to access in place. Information was collected via semi- structured interviews which offered flexibility in the data collection process. Interviews were recorded, transcribed and then subjected to thematic analysis to identify the main issues emerging from participants [15]. This qualitative research was based on a phenomenological approach, designed to explore experiences from the perspective of participants. This research had ethical approval from the Department of Applied Social Sciences of Limerick Institute of Technology (LIT).

Results

Results of thematic analysis identified four distinct themes: Stress; Burnout; Support; Training. A significant theme to emerge was how stressful participants found having to administer Naloxone. It is clear that participants struggled with having to administer Naloxone, and were left questioning their skills in the face of such a traumatic event (See theme A, Stress in Table One)..

Table One: Four Themes Identified Through Thematic Analysis

Theme	Quotation
A) Stress	*"It's a very stressful event. The first overdose that I was involved in that required CPR and naloxone was a bad one. The client was not responding to the naloxone, and didn't respond to any of the naloxone that we administered...so when they left with paramedics we were not sure that that person was going to make it so that was quite a stressful one..."*
B) Burnout	*"I find especially if an overdose happens at the start of a shift and you have forty clients then to look after, by the end of the shift you are burned out by the time you go home."*
c) Support	*"I have done PFA once after it was a fatal overdose, and that's why I did PFA. But if they're like non-fatal… when you know the person is going to be okay, then usually I wouldn't… I would decline it."* *"Talking to a supervisor or someone like that, that has never responded to an overdose before. I just feel like I'd struggle with that because, I'd be like, you don't know what I'm talking about. It does be like talking to a wall"*
D) Training	*"I did training in naloxone… maybe two and a half years ago. Since then we actually haven't had it [again], which I think is a shame… because we have high levels of overdoses happening… I think we should have refreshers at least every six months"*

The second theme to emerge was that of burnout. The stress of administering Naloxone was exacerbated by low staff numbers, high client numbers and the chaotic nature of the work environment (See theme B, Burnout in Table One). Support was the third theme to emerge (see theme C, Support in Table One). Participants were routinely offered Psychological First Aid (PFA). However, one alarming aspect to emerge was the apparent reluctance of participants to

engage with such structured supports. Participants noted how they might be offered debriefing support by a supervisor, but how they would struggle with this support if the person providing it had not gone through a similar experience. The fourth theme identified was that of training. Naloxone training was generally well received. However, it should be noted that some respondents did feel that refresher training should be routinely provided.

Discussion

Although it is important to acknowledge the limitations of this study, most notably in terms of its focus on just one agency and its relatively small sample size, the findings are nonetheless significant. It is no surprise that the primary theme to emerge from this research is that of stress. The act of having to administer Naloxone in a potentially life and death scenario is intensely stressful for most people, particularly those with relatively little health training and experience. The issue of burnout resulting from this stress is however highly significant. Although the potential for burnout resulting from prolonged exposure to these forms of stressors is well known among medical staff, paramedics, nurses and other emergency workers, it is less well acknowledged in the field of Social Care Work. The potential rejection by Social Care Workers of crucial post-incident supports is a vital issue which needs to be addressed. Similarly, refresher Naloxone administration training should be offered on a six-monthly basis. It is recommended that more robust policies are implemented governing the provision of counselling support following opioid overdose in social care work settings. It is also recommended that an on-call system is introduced whereby relief staff can be brought in following an overdose incident. This would facilitate mental processing, recuperation, support interventions and administration association with the incident.

Declaration of Conflict of Interest:
The authors have no conflicts of interest to declare.

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