Improving Access to Quality based Opioid Treatment

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Situational analysis of drug and alcohol issues and responses in the Pacific, 2008-09
Political and moral values of the social system

A model for evidence-based clinical decisions
(from Haynes et al., 1996)
Classification of Addicts and Recommended Treatment

Types of Addicts
- Correctional cases
- Mental defectives (degenerates)
- Social misfits
- Otherwise normal

Treatment
- Internment camps
- Sterilization
- Vocational guidance
- Psychoanalysis

American Medical Association 1930s Indications for Treatment
Global Opioid Use

- 16.5 million globally abuse opioids (2008)
  - 12 million use heroin
  - ≈ 93,000 dependent users in Australia

- Significant premature mortality
  - 2-5 percent untreated die per year
    - Half due to heroin overdose
    - Around 13 times more likely to die than age sex matched
    - Three times more likely than those in treatment

- Significant social and economic costs
  - Crime, unemployment, social problems

- 30% HIV outside Sub Saharan Africa
  - 30% of these infections involve IDUs
Reports of injecting drug use in 151 countries

Global estimate of the number of IDUs: 15.9 million (11.0-21.2 million)
Opioid substitution therapy (OST)

Present in 75 countries
Absent in 76 countries where injecting occurs
Reach

- **62 Countries Methadone**
- **35 Countries Buprenorphine**
  - Methadone and Buprenorphine classified by WHO as essential medicines
- **OST Commenced in Australia in 1969**
  - 41,347 pharmacotherapy clients (2008)
    - 10% recurrent growth until 2003 then plateaued
    - Unmet need around 41,000
    - Majority of treatment episodes in PHC
Opioid Substitution Treatment

- Strong evidence for the benefits of oral methadone treatment RCTs +++ REASONABLE EFFECT SIZE
- REDUCES DRUG CRIME .70
- REDUCES OPIATE CONSUMPTION .35
- REDUCES INJECTING & RISK TAKING 0.22
- REDUCES RISK OF OVERDOSE DEATH
- Now good evidence for buprenorphine and RCTs ++
Buprenorphine maintenance

- Partial agonist that exerts weaker opioid effects at opioid receptors
- Research from USA, Austria, Italy, Iran, Australia
- Methadone more likely to retain patients in treatment than buprenorphine (MMT: 63%, Bup: 53%; Mattick, 2002)
- No significant difference between methadone and buprenorphine in reducing heroin use, cocaine use, benzodiazepine use or crime (Mattick, 2002)
- Buprenorphine better than placebo in terms of retention and heroin use
- Poorer retention for buprenorphine requires investigation (patients may have been inducted too slowly)
- More research needed on other outcomes: self-reported drug use, crime, physical health and psychological health
Getting to this point: growth & expansion

- 1990’s: ++growth in heroin use & related ‘crises’: HIV, ODs, HCV
- Challenge was to expand treatment numbers quickly
- *Buprenorphine* introduced 2002
- Expansion into private sector: GPs & pharmacies
OST in Australia: an exhausted sector

- “Too difficult to recruit doctors” ... “GPs do not want to treat opiate users”
- Whither ‘shared’ care?
  - Addiction treatment sector not oriented towards primary care
  - Almost no multidisciplinary community services
- Plateau OST numbers
Prescription opioid use 1992-2007
Leong, Murnion, Haber IMJ 2009
Dependence to pharmaceutical opioids

- Chronic pain: 30% adult population (5-10% severe) (AIHW)
  - Increasing amounts of opioids being prescribed in response
  - Opioid dependence estimated in 10% of chronic pain patients taking opioids (range 3 to 20%)
  - 10% of 5-10% of 15M adult Australians = ?75-150,000 pharmaceutical opioid dependent
  - GP surveys: ?150-200,000 pharmaceutical opioid dependent

- In context: ~ 93,000 regular heroin users (Ritter et al 2009)
We have an OST system... 

- oriented towards treating heroin addiction 
- that is ‘higher threshold’ than getting pharmaceutical opioids 
- not suited to responding to the new wave of opioid dependence in Australia today
Have we got OST right?

- Australian methadone and BPN treatment conditions designed for treating marginalised heroin addiction
  - not suited to treating pharmaceutical opioid addiction
- BPN treatment ‘copied’ methadone treatment
  - We are not getting potential benefits of freeing up treatment that is afforded by Suboxone
- Time for a rethink?
  - French & US models indicate less restricted roll-out BPN / BNX achievable with positive outcomes
International experiences

- **France**
  - Introduced BPN 1996 minimal infrastructure: no GPs training, no guidelines, no patient registration, no supervised dosing
  - Methadone in public clinics
  - Outcomes: >100,000 BPN & >20,000 M, big reductions drug-related deaths & HIV

- **USA**
  - Suboxone 2000 ‘office based’ system to avoid over-regulated methadone clinics
  - Minor regulatory controls: Minimal training, no supervised dispensing
  - Outcomes: large & rapid expansion treatment capacity, capturing new prescription drug users, few documented problems re: diversion / harms.
Moving forward ...
Polygon report ....

- Affordable treatment
- Accessible treatment
- Address non-adherence
- Service system models
Results: Key issues

1. Program goals
   - Are there shared program goals?
   - Abstinence vs harm minimisation

2. Service delivery models
   - Public clinics vs GP/primary health care services
     - relative mix (63% GP 80% Community Pharmacy)

3. Affordability of the program to patients
   - Patients incur costs: dispensing fees, other costs
   - Most significant cost is dispensing fees (80% pay)
   - Many reports of difficulties with payment
   - Inequitable
Results (cont.)

4. Accessibility of the program
   - Access to prescribers and to dispensing services problematic
   - Geography matters

5. Medication non-compliance and diversion
   - Non-compliance is normal; diversion is problematic
   - Minimise harms to individuals and to the program

6. Unsupervised dosing
   - Terminology: take-aways versus unsupervised treatment
   - Supervision critical first 6 months
   - Models of care: eg unsupervised treatment for long term stable clients
Other issues

- Role of counselling
- Pharmaceutical opioid use and misuse
- Meaningful consumer involvement in the program
- Creating and sustaining the workforce
- Prisoners and pharmacotherapy maintenance
- Rural and remote issues (geography)
- Stigma
CONCERNS

- Limited OST availability compared to scale of need
- Client co-contribution considerable and real barrier to access
- Limited buy in by PHC (5% of GPs)
- Stigma and discrimination persists
- Increasing numbers of prescription opioid dependent people
Options

- Section 85 inclusion
- Complex patients referred to Addiction Medicine Specialists
- Suboxone authorisation requirements reduced
- Unsupervised dosing
- Unsupervised treatment
- Nurse practitioner prescribers
- Greater NGO role for psychosocial support
International experiences

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International experiences

Issues in UK and EU

- Growing debate on the relationship of recovery to treatment,
- Marked funding squeeze on residential sector perception that methadone with not great outcomes dominating
- A debate on quality and duration of methadone treatment in UK and Ireland
- Need for broader treatment planning and better case review across the board.
Criticism of existing services now too narrowly focused not adequate planning across different treatment modalities and poor linkage and care planning across different modalities,

Problems with ageing treatment cohort now moving towards issues of methadone in residential care for the elderly
Poly drug use population with mixture of alcohol, benzodiazepine and opioid and heroin dependence
“The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society”.

www.ukdpc.org.uk/resources/avisionofrecovery.pdf
Recovery definition

- Aspirational vision
- Inclusive of abstinence and maintenance goals.
- Recovery more than dealing with harms.
- Must encompass building a fulfilling life.
- Relationship with the wider world is part of the recovery process for an individual.

In our field this requires a long-term commitment and a balance of specialist care and building recovery capital.
What predicts recovery?

- Resilience to social stressors.
- Social supports.
- Family life.
- Identity shift to functional from dysfunctional.
- Employment.
- Stable housing.
Personal recovery capital

- Physical
  - Physical health
  - Financial assets
  - Health insurance
  - Safe and recovery conducive accommodation
  - Clothing
  - Food
  - Access to transportation

- Human
  - Values, knowledge, education/vocational skills
  - PS capabilities
  - Self-awareness – esteem – efficacy
  - Hopefulness/optimism
  - Perceptions of past, present, future
  - Sense of meaning & purpose in life
  - Interpersonal skills

Relationships

- Intimate relationships
- Family & kinship relationships (family of choice)
- Social relationships supportive of recovery

Indicators

- Willingness of partners/family to participate in treatment
- Presence of individuals in recovery in the family & SN
- Access to sober outlets – sobriety based fellowship/leisure
- Relational connections e.g. school, workplace etc

Community recovery capital

- Community attitudes/policies/resources related to addiction and recovery that promote resolution of substance use disorders
- Active efforts to reduce addiction/recovery stigma
- Visible and diverse local recovery role models
- A full continuum of addiction treatment resources
- Recovery mutual aid resources that are accessible and diverse
- Sources of sustained recovery support and early re-intervention
- Cultural capital – availability of culturally prescribed pathways of recovery
Recovery

- **Treatment Renewal Movement**
  (e.g. continuum vs. unit or episode, medication assisted treatments, performance and outcome, etc.)

- **Recovery Advocacy Movement**
  (e.g. support groups, clubhouses, recovery support centers, recovery housing, recovery educational programs, recovery job co-ops, etc.)

In UK broad debate on definition of recovery with an important emphasis on the value of medication treatment as a core part of recovery

Also focus on developing recovery advocates who are external to and beyond traditional treatment delivery “Recovery Advocates”

A real risk that a vigorous recovery debate polarises the field into abstinence versus medication and overall regressive approach
Issues for Treatment re Recovery

- Greater focus on what happens BEFORE and AFTER primary treatment
- Transition from professional-directed treatment plans to client-developed recovery plans
- Greater emphasis on the physical, social and cultural environment in which recovery succeeds or fails
- After Bill White et al
Excess mortality ratio for different time periods post-release by cause of death (Singleton, Farrell, Marsden et al 2003)

- Up to 1 week
- 1 up to 2 weeks
- 2 up to 4 weeks
- 4 up to 8 weeks
- 8 up to 13 weeks
- 13 up to 26 weeks
- 26 up to 52 weeks
- >=52 weeks
- Total

- Drug-related deaths
- Not drug-related
Post-release mortality rates (males)
Farrell & Marsden [2008] n = 36,515
Post-release mortality rates (females)
Farrell & Marsden [2008] n = 12,256
Prison Release Mortality
Total Sample 183780

Deaths per thousand person years  Metanalysis Merrill et al 2010 Addiction
# Meta-analysis of major studies: when

<table>
<thead>
<tr>
<th>Country: studies</th>
<th>Drug-Related Deaths (person-years)</th>
<th>RR in 1st fortnight (95% CI)</th>
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<tr>
<td></td>
<td>DRD Rate per 1,000 pys</td>
<td></td>
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<tr>
<td></td>
<td>Wks 1+2</td>
<td>Wks 3+4</td>
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<tr>
<td><strong>UK: E&amp;W + Scotland</strong></td>
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<tr>
<td></td>
<td>92 (2,588) 36</td>
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<td>187 (7,759) 24</td>
<td>64 (7,416) 9</td>
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<td>27 (1,466) 18</td>
<td>5 (1,426) 4</td>
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<td><strong>USA: State = New Mexico</strong></td>
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<td>8 ( 462) 17</td>
<td>3 ( 462) 6</td>
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</table>
Risk on release from residential and inpatient treatment

- Preliminary data indicates elevated risk but not very well enumerated
- Need for bigger cohort studies to clarify risk and protective factors
- Need good education for individuals and families about possible risk and approaches to reduce risk
Risk on starting and stopping medication

- Methadone risk doubles in first two weeks to month and then settles.
- Risk increases significantly on departure from methadone and buprenorphine.
- Also risk high after oral naltrexone, risk high after stopping depot naltrexone.
- Need more work to understand the additional deaths that may occur if unbalanced push towards recovery and abstinence.
Conclusion

- Pharmacotherapy highly cost-effective
- Australian has a good service system but:
  - Relies predominantly on community care models
  - Affordability for patients is problematic
  - Availability of treatment is limited
  - Diversion threatens the program
  - Stigma is attached to the program
  - Recovery not part of current language
  - Risk inherent in approaches to med cessation
Further information

Reports available at:

DPMP Website:
http://www.dpmp.unsw.edu.au