Presentation: **Reflections on OTS**

D G Chaplow 8 May 2014, Waikato

Introduction

My reflections come from a 10-year involvement in the sector which included being part of the developing guidelines (2008)[i]. The presentation is a reflection on the many issues that beset and challenge those working in the sector.

History of methadone used in treatment, pluses and minuses

We take a lot for granted. Methadone Maintenance Treatment (MMT) was developed post-WWII in response to a heroin epidemic in New York City[ii]. The principle aims of the time were to reduce narcotic craving and block the euphoric effects associated with heroin. It was a 'corrective' not 'curative' remedy. Additional aims have since been established; namely

- To minimise the spread of HIV and AIDs, and
- Reduce the criminal and associated dissocial aspects of narcotic addiction

It has always been a principle that methadone maintenance coupled with psycho-social intervention is the most effective treatment for addiction.

Daryle Deering in her Doctoral thesis[iii] stated, *"…paired comparisons showed a significant reduction in injecting drug use, a high reported opioid abstinence rate as well as a significant overall reduction in benzodiazepine use…."*, supporting the general effectiveness of MMT.

A similar study conducted in Australia[iv] stated that MMT had been used there since 1970 but had resurgence in use with the threatened epidemic of AIDs and HIV in 1985. In this regard the MMT model had been very effective.

One of the on-going debates is how we conceive of addiction. It has variously been conceived of as an individual, medical, legal and moral problem. From the mid-19C it has been seen as an illness of individuals who are to blame for a self-inflicted problem. Amidst the many disadvantages, the 'medical model' has influenced governments and moved the agenda from 'punishment' to 'treatment'. Its disadvantage is that it is very narrow in its conception of the many contributions to the problem.

Early researchers Dole and Nyswander argued that addiction was a disease involving metabolic deficiency[v]. They likened MMT of addiction to that of person with diabetes taking insulin over a life time. They furthered argued that it gave the individual the opportunity to improve their social situation and 'take advantage of the psychotherapeutic and rehabilitative services that were an integral part of the program'. The program was also believed to lessen the need for criminal activity.

Indeed, a team of investigators from the Addiction Centre[vi] found in their study (N=85, of Maori and non-Maori) that *'considerable reductions in the frequency of crime control occurred with 60% of participants reporting they committed crimes every day before MMT compared with only 1% at interview'.*

10 things we know about addiction[vii]

Doug Sellman gives a list, which are a thoughtful introduction to what I have to say

i) Addiction is fundamentally about compulsive behaviour
ii) Compulsive drug seeking is initiated outside of consciousness
iii) Addiction is about 50% heritable and complexity abounds
iv) Most people with addictions who present for help have other psychiatric problems as well
v) Addiction is a chronic relapsing disorder in the majority of people who present for help
vi) Different psychotherapies appear to produce similar treatment outcomes
vii) 'come back when you are motivated' is no longer an acceptable therapeutic response
viii) The more individualised and broad-based the treatment a person with addiction receives, the better the outcome
ix) Epiphanies are hard to manufacture
x) Change takes time

Guidelines for NZ/Misuse of Drugs update

The guidelines were promulgated in 2008 and may have been updated by now in the light of the recent review and update of the Misuse of Drugs Act 1975 update. We will hear all about this in the next presentation.

Our aim at the time was to give expression to some of the early leaders of MMT (Nyslander et al) who were clear that the programme was only effective if medical stabilisation went hand-in-hand with psychosocial intervention. If the two aren't linked the programme becomes a legalised opiate supply service (which admittedly while having some advantage to the end-user, is not a good use of the resource being committed to the challenge).

The other aim, aside from giving guidelines on the technicalities of service delivery, was to convey a sense of the importance of the systemic issues. This is in recognition that addiction rarely stands alone and that families are adversely affected, general health is adversely affected and that treatment requires a 'triangulation' between the specialist services, the GP the client and the family.

Whether practical or not the initial intention was that all clients initially present to the specialist addiction service and after a period of assessment and medical and psychosocial stabilisation, they be decanted off to primary and/or authorised services. The practical challenges are that the bulk of the cohort of clients are invariably quite disabled individuals who often choose to remain with the specialist service on account of having a primary therapist, an established working relationship and quick access and response to their life problems. There are other challenges also regarding the capacity, willingness and capability of primary practitioners and their ability to maintain safe services and adequate peer-review and support. The issue of funding has largely been removed by the willingness of DHB to provide bridging finance to services who take on this role.

I raise blocks of issues for thoughtful discussion.

The issues:

a) Philosophic differences
    a. Patient knows best vs. prescriptive approach
    b. Abstinence vs. harm-minimisation
    c. Unified approach vs. individualised approach
    d. In-/toleration of protocol violations

These are 'old-chestnut' issues. When I first had anything to do with OTS services I enquired how a clinician set the initial doses. Feedback varied between following the guidelines to 'listening to what their body tells them'. I wasn't sure what this meant. In services surveyed most clients are receiving 80-120 mgs /day. A few are receiving high doses (in excess of 150 mgs/day) and some, very high (300mg/day). I presume, apart from diversion, this is accounted for in terms of personal pharmacokinetics, body weight, and variations in metabolism.

Most practitioners would accept the 'harm-minimisation' hypothesis as valid. Many addicts though will still aim for total abstinence.

The response to protocol violation, in my experience, is very dependent on the leadership. I am mindful of Doug Sellman's list that addiction for many is a chronic relapsing disorder and that if a violation can be re-framed as an opportunity for learning, so much the better.

b) Pain clinics/OTS
    a. Demographics
    b. Known deaths
    c. What to do

One of the fallacies is that methadone is a safe drug. In fact it is highly addictive and its advantage and disadvantage is that it has a long half-life (60 hours cf. heroin of about 6 hours). This makes it ideal to replace heroin, but dangerous for naïve users who may not be able to assess its immediate effects and take too much. Its steady state in the blood stream is about 4-hours if taken orally. This means that naïve uses expecting a 'kick' may be tempted to take more.

One of the frustrations I had as director was in protecting the reputation of the OTS when an untimely death occurred. These may have been due to a MVA where the alleged perpetrator was taking methadone; where methadone was diverted to a naïve user without any titration of dose, or, indeed, when an enraged person stabbed another with a barrel of methadone. The NZ Med J published an article in 2005[viii] taking its research from reported deaths from 2001-2002. The findings were that 31 of 92 poisoning deaths occurred in that period due to methadone. What was not made clear in that article was that about half of all these deaths were from methadone prescribed by 'pain clinics' and diverted to friends and/or for profit. A survey of prescribing of the two cohorts commonly finds very much higher doses of methadone given for pain. Many sufferers remain for years under the pain clinics before being referred to the OTS on account of their addiction to methadone. The answer seems fairly straight forward to me in that communication between the two services seems appropriate as, indeed, is happening in some DHBs.

c) Other Challenges
    a. Dispensing
    b. 'Take-aways' and diversion
    c. Funding
    d. Co-morbid addictions
    e. Interim prescribing

In the business of our own assessment and treatment challenges it is easy to forget the challenges for the private pharmacies. In one DHB in NZ all the recipients had to line up outside the one dispensing pharmacy before it opened to the public. Any infraction of order was dealt to by a banning of that person. Another pharmacy impressed by their willingness to build on an annex that provided a separated area from the public, allowing some privacy for the individual addict.

Identification remains an issue. ID from photos is usually hopeless. Pharmacy shopping still occurs, commonly out of area and until we have iris screening and rapid communication between pharmacies and OST services we will have challenges.

The ability of gazetted doctors to authorise other doctors in far-flung places is yet another problem. This arises from the mobility of addicts and commensurate difficulties in them getting accepted into the new location treatment service. It is no-one's fault; just another hurdle to overcome. Interim prescribing has been proposed but there are understandable challenges with this and reluctance by many services to take to it. Discussion on this aspect of service provision would be welcome.

<u>Summary and conclusions</u>

I to make a few concluding points:

- OTS services remain valuable and necessary
- MMT methodology is best utilised when medical stabilisation operates hand-in-hand with psychosocial servicing
- Primary services, NGOs, and families need to work in conjunction with the specialist services. The assessment/treatment continuum needs to be comprehensive and inclusive and be made clear from the outset of the first assessment
- Services need to be open to scrutiny. This is best done by regular reviews of difficult-to-manage clients by invited senior clinicians
- DHBs and the MoH in conjunction with the Addiction Centre need to continue to champion the cause of OST/MMT in monitoring and advocating for clients who use the system
- Methadone prescribing by the MMT programmes and by the pain clinics need close collaboration

References

[i] 'Practice Guidelines for Opioid Substitution Treatment in New Zealand 2008' Ministry of Health, Wellington

[ii] Joseph H et al (2000) 'Methadone maintenance treatment: a review of historical and clinical issues', Mt Sinai J Med Oct-Nov; 67(5-6): 347-64

[iii] Deering D (2007) Methadone Maintenance treatment in New Zealand

[iv] McArthur M (1999) Presentation Canberra, 'A History of Methadone Treatment in Australia: The influence of social control arguments in its development

[v] Dole V, Nyslander M (1967) 'Heroin Addiction-a metabolic disease' Archives of Internal Medicine 120, pp 19-20

[vi] Sheerin I et al (2004) 'Reduction in crime by drug users on a methadone maintenance therapy programme in New Zealand' J of the NZMA Vol. 117 No. 1190

[vii] Sellman D (2010) 'The 10 most important things known about addiction' Addiction, 105: 6-13

[viii] Reith D, Fountain J, Tilyard M; (2005) 'Opioid poisoning deaths in New Zealand (2001-2002)'; J of the NZ Med Assoc. Vol. 118, No. 1209