Opioid Substitution Treatment

Prof. Dr. Heino Stöver

Prof. Dr. Jörg Pont

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Andrej Kastelic, Jörg Pont, Heino Stöver

Opioid Substitution Treatment in Custodial Settings

A Practical Guide

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www.unodc.org/documents/balticstates/Library/PrisonSettings/OST_in_Custodial_Settings.pdf

Opiates in treatment for opiate dependency

Agonists (Methadone, slow release morphines) and **partial agonists** (Buprenorphin):

Substitution treatment

Opiate-like effect

Stimulate opiate receptor

Alleviate/stop craving

No rush

Maintain physical dependence

Antagonists

(naltrexone and naloxone)

Blocking or aversion treatment

Block action of opiates

Block opiate receptor

Don‘t alleviate craving

No rush

No physical dependence

Goals of substitution treatment

- Reduce the use of illicit drugs
- Reduce injecting drug use and concomitant harms
- Reduce the risk of drug related death
- Enable to undergo and maintain treatments
- Reduce re-offending and re-imprisonment
- Stabilize personal, social, professional life
- Improve health and well-being

Substitution strategies

Detoxification:	short-term (<1mo)
	long-term (>1mo)
Maintenance:	short term (>6mo)
	long-term (>6mo → years)
Low threshold:	easy entry, harm reduction and QoL oriented, flexible
High threshold:	selection criteria, abstinence oriented, regular urine testing, inflexible discharge policy, compulsory psychotherapy

„no single treatment is effective for all individuals, therefore services should be sufficiently varied and flexible to respond to the needs of clients, their severity of dependence, personal circumstances, motivation and response to interventions. The rational management of opioid dependance calls for the balanced combination of pharmacotherapy, psychotherapy, psychosocial rehabilitation and risk reduction interventions.“

WHO/UNODC/UNAIDS 2004

Requirements for substitution treatment

- Diagnosis of opiate dependency
- Fully informed consent including
  - limits of confidentiality (registration)
  - control of intake and other rules
  - obligations of patient and therapist
- Individualized dosis and treatment
- Avoidance of stigmatisation
- Treatment of co-morbidities

OST and infectious diseases HIV/HC and TB

- OST stabilizes lifestyle for undergoing treament without interruption
- Challenging management of side effects and drug interactions

Substitution agents

Medication Route	q	Starting dose	Dose range	Increase by decrease by	Overdose risk	Withdrawal
Methadone oral-enteral	q 24 hours	10-20 mg	40-120 mg	10mg/ wk 5mg/wk	+++	++++
Buprenorphine sublingual	q 24 to72 hours	4-8 mg	8-24 mg	2-4mg/wk 2mg/wk	+	+
Slow- release morphine oral-enteral	q 24 hours	60 to 200 mg	400-1200 mg	30-60mg/wk 30-60mg/wk	+++	+++

Methadone

Side effects

QT prolongation
Increased perspiration
Constipation
Sleep disturbances
Reduced libido
Reduced concentration
Weight gain

Protracted detoxification

Metabolism:

t/2: 20-37 (10 -80) hours
Cytochrome P450
Inhibitors
- Antifungals –azoles
- Antiretrovirals
- Macrolides
- Grapefruit

Inducers
- Alcohol
- Aniticonvulsants
- Antidepressants
- Antiretrovirals
- Rifampicin

OST: Evidences from Metaanalyses

- Reduction of mortality (M>B)
- Reduction of illicit drug use (M>B)
- Reduction of HIV infection rate
- Reduction of relapse rate
- Retention in care and treatment
- Decrease in criminal activity
- Cost-effective (M>B)
- Higher doses > lower doses
- Adjusted doses > fixed doses
- With psychosocial treatment lower relapse rate

WHO 2009, Mc Arthur BMJ 2012, Gowing Cochrane DSR 2008, Mattich Cochrane DSR 2014

OST and pregnancy

- Methadone safe, buprenorphine less data
- Cave withdrawal: risk of spontanous abortion

  in 1st trimesterand premature labour in 3rd trimester
- 2nd and 3rd trimester: increase dose of methadone (increased metabolism)
- Cave: neonatal abstinence syndrome (shorter with buprenorphin)
- Breast feeding possible (low methadone levels in milk)

OST for dependent prisoners

- Improves prison safety (less drug seeking behaviour)
- Reduces self-harm and suicide in prison
- Reduces post-release death rate
- Reduces re-offending and re-imprisonment
- Facilitates treatment and care during and after imprisonment

Requirements for OST in prison

- Appropriate staffing
- Training of medical and non-medical staff
- Professional independence of health care staff
- Interprofessional co-operation
- Communication with community services
- Continuity of care on transfers and release
- Monitoring, evaluation and optimisation

The essence of medical ethics in prison

1. The primary task of the prison doctor and the other health care workers is the health and well-being of the inmates.
2. The 7 essential principles for the practice of prison health care, as set out by the CPT:

- Free access to a doctor for every prisoner
- Equivalence of care
- Patient consent and confidentiality
- Preventive health care
- Humanitarian assistance
- Professional independence
- Professional competence

Medical ethics and OST in prison

- Free access to detoxfication and maintenace OST, psychosocial care and continuity of care
- OST according to need of the individual patient and not to the needs of the prison: Complete professional independence in indication, doses and treatment recommendations
- Equivalent services and choices as in the community
- Continous informed consent and as much confidentiality as possible
- Close cooperation with community services for continuity of care
- No involvement in drug testing or drug checks for security reason

Group work: OST in prison

1) How would you explain the benefits of OST programmes in prison to lay persons?
2) What are/were the greatest obstacles to implementation/roll-out of OST programmes in prisons and how to overcome them?
3) Describe adverse side effects of OST in prison as observed or reported and recommend strategies to minimize them

Short term detoxification

Methadon: 10-20 mg/d, reduce 1-2 mg/day

Buprenorphin: 10 mg/d, reduce 2mg/day

α-adrenergic agonists

Clonidin 4 x 100-300mg taper over 5 days
Lofexidin 2 x 0.4-0.6 mg taper over 7 days
Guanfacin 1 x 0.25-0.5 mg taper over 3 days

Risks of substitution treatment

- Fatal overdose
- Diversion of drugs, abuse and trafficking
- Stigmatisation