Integration of pharmacotherapy of opioid dependence into primary health care

International Conference
HIV Prevention Among Injecting Drug Users and In Prison Settings

Riga, Latvia, 24-25 March 2011
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Treatment of large number of individuals with OST demands the development of programs that are incorporated within general primary health care and welfare services.
Contents

I. Conditions of OST in Germany
II. To be more general ...advantages and disadvantages
III. IMPROVE-study
IV. OST in prisons
History of OST in Germany*

- only introduced late 80s (pilot only in one „Länder“)
- health impact only at the end of the 90s
- commissions (3 GPs) decided on access
- limited access for special target groups first
- „ultima ratio“
- National guidelines/regulations on OST
- psycho-social care: as obligation, but gaps in provision
- Paid by local municipalities
- Contents very heterogenous
- Client-social worker relation varying: from 25 to 1:250
- few scientific data on effectiveness
- barrier for commencing or continuing OST

Registered OST medications in Germany

- Methadone
- Levomethadon
- Buprenorphine
- Buprenorphine-Naloxone-combination
- Diacetylmorphine (only in specialised centres)

Supervised dosing, take-aways for ‘stable’ patients

Methadone register: mechanisms to prevent ‘doctor shopping’
OST Provision Integrated into Primary Health Care: Example of Germany 1/3

- Goal of „normalization“ of (opioid) dependence as „normal disease“
- GP‘s expertise in pharmacotherapy: tobacco, alcohol dependence
- Easy access to GPs all over the country
- OST prescription: every GP after registration (approx. 2,700)
- Mandatory training (50h)

Key premises of drug dependence treatment in Germany 2/3

- Drug dependence is not substantially different than any other chronic diseases
- Drug addicts are not different than other patients
- Opiate agonists are not substantially different than other medicine
- Treatment is integrated in existing/well integrated health care structures
- OST provided exclusively by GPs
OST Provision Integrated into Primary Health Care: Example of Germany 3/3

But...

- OST still perceived as „dirty medicine“ instead of addiction medicine*
- Gaps in provision of OST: north-south, east-west, urban-rural, community-custody
- Unfavourable conditions =>

Unfavourable conditions for OST

- Increasing administrative controls
- Juridical consequences – sanctions and punishment
- Complex treatment: increasing co-morbidity of patients
- Low remuneration
- Often missing (required) psycho-social care

Source: Umfrage der Bundesärztekammer: Prägende Faktoren der Substitutionsbehandlung (Kunstmann 2008)
Adoption of OST: community vs. Prison setting

OST in the community - Orange line
OST in prison - Blue line

Countries: CZ, RO, NO, SK, LV, LT, BG, FR, HU, BE, PL, GR, DE, IE, SI, ES, HR, MT, AT, LU, UK Sc, NL, DK, FI, SE, IT, PT, NL, DK, DE, SI, ES, PT, CZ, CY, SE, RO, BG, EE


www.emcdda.europa.eu
Numbers of opioid substitution treatment patients, accredited physicians and actively treating accredited physicians in Germany


Source: Bundesinstitut für Arzneimittel und Medizinprodukte, January 2010
Authorised doctor’s reasons for providing OST – or not...

Source: Ergebnisse einer Stichprobenuntersuchung von n=2045 Ärzten, die 2003 nicht substituierten, obwohl sie die Qualifikation dazu hatten (n. Wittchen 2007)
Stimmt die Ergänzung:
"obwohl sie die Qualifikation dazu hatten ??
X Stöver
SC, 09/19/2008
Shared care model – few additions

- interdisciplinary teams: GPs, psychologists, social worker, nurses…
- few centres for outpatient treatment and GPs
- resulting from lack of service provision in the municipality/region
- specialised centres for certain target groups
- Focal treatment points (GPs + other specialists, plus nurse and social worker) in bigger cities
Coverage rates

- > 50% in the community are in OST (80,000 out of 150,000)
- Coverage lacks in other settings:
  - prison + other custodial settings: 3-5%
  - medical rehabilitation >3%
  - forensic psychiatry < 1%
- Very poor and patchy in some regions
- Very heterogeneous
Outcomes and indicators

- Retention rate, estimated > 80%
- Overal mortality < 1% annually *
- HIV infection <9% (annual incidence rate)
- HCV pos. >50%

* Bundeskriminalamt (www.bka.de)
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I. Conditions of OST in Germany

II. To be more general ...advantages and disadvantages

III. Study „IMPROVE“

IV. OST in German prisons
Organisation of substitution treatment

General practitioner’s:
Austria, Belgium, France (buprenorphine), Germany, Ireland, Luxembourg, UK, Denmark

Specialised centres:
Denmark, France (methadone), Italy, the Netherlands, Portugal, Spain

Specialised centres, limited number:
Finland, Greece, Sweden, Norway

1 EMCCDA, 2002
Advantages - OST in Primary Health Care

- High availability
- Integrative approach - holistic care
- De-Stigmatisation
- Normalization of dependence treatment
- Low costs
- GPs as “gate keepers”
- OST free of charge
Disadvantages

- Difficult to assure quality of treatment
- Easier diversion/safety issues
- Lost of universal epidemiological data
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IV. OST in prisons
Study „IMPROVE“¹:
Achieve better understanding of the barriers to OST access, retention and quality

- Patients: Opioid-dependent persons currently in treatment (n=200)
- Users: Opioid-dependent persons not currently in treatment (n=200)
- Treating physicians: OST-accredited physicians who currently provide treatment (n=101)
- Non-treating physicians: OST-accredited physicians who do not currently provide treatment (n=51)

Key findings of the “IMPROVE” survey

- OST valuable & effective by physicians, patients, users
- OST access and provision are inadequate, especially outside of major cities
- Improvements in the regulatory framework and conditions for OST would encourage more accredited physicians to actively provide treatment
- Medication misuse and diversion do occur and are a significant concern for physicians.
- The opportunity to stabilise the condition of opioid-dependent individuals who cycle in and out of prison, by commencing or continuing treatment during their incarceration, is being lost
Degree of Difficulty for Patients to get access to ST in Area

Overall, only 38% of all physicians say that access to ST in their area is easy or very easy. In North/West access is much easier than in the East/South. Access is easier in larger cities.

<table>
<thead>
<tr>
<th>Difficulty Level</th>
<th>Total</th>
<th>Treating Physicians</th>
<th>Non-Treating Physicians</th>
<th>Treating Physicians</th>
<th>Size of City</th>
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<td>North/West</td>
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<tr>
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<td>(3) Neither easy nor</td>
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<tr>
<td>difficult</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(4) Easy</td>
<td>26</td>
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<td>(5) Very easy</td>
<td>13</td>
<td>13</td>
<td>12</td>
<td>8</td>
<td>11</td>
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</table>

Results in %
Base: All respondents
Q21a In your view, how easy is it for patients in your city or region to get access to substitution therapy?
Barriers that Restrict Patients from Entering ST

Biggest barriers for patients against entering ST are the strict rules they have to follow, the poor availability of physicians and the related waiting lists.

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Total (n=152)</th>
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<th>Non-Treating Physicians (n=51)</th>
<th>Treating Physicians North/West (n=40)</th>
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<td>Strict rules of treatment e.g. urine testing, daily supervision,</td>
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<td>mandatory counselling, expectation of abstinence</td>
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<td>65</td>
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<td>39</td>
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<tr>
<td>Stigma</td>
<td>39</td>
<td>39</td>
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<td>33</td>
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<tr>
<td>Lack of awareness of how to get treatment</td>
<td>32</td>
<td>32</td>
<td>33</td>
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<td>31</td>
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<tr>
<td>No psycho-social counselling available</td>
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Results in %

Base: All respondents

Q25a I will now read you a list of barriers that might prevent patients from entering substitution therapy. I'd like you to tell me which of these barriers you feel exist in your state or region. After reading out: Can you think of any factors, apart from those I just read to you, that prevent patients from entering substitution therapy?
Conclusions „IMPROVE“

- Clear opportunities for improving access to high-quality treatment through optimisation of treatment structures/regulations and the increased education and support of patients/physicians.
- Results highlight the need for providing sufficient guidance to support physicians in providing high-quality clinical care based on (1) a sound understanding of the advantages/disadvantages of different pharmacological therapies and (2) the individual needs of each patient.
Study „IMPROVE“:
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Mean
- Very difficult: 2.9
- Easy: 2.9
- Neither easy nor difficult: 3.0
- Very easy: 2.6

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### IDUs, drug-related infectious diseases in German prisons

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<thead>
<tr>
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<th>IDUs</th>
<th>HCV</th>
<th>HIV</th>
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<td><strong>Prisons</strong></td>
<td>21.9%</td>
<td>14.3% *</td>
<td>1.2% **</td>
</tr>
<tr>
<td><strong>General population</strong></td>
<td>0.3%</td>
<td>0.4–0.7%</td>
<td>0.05%</td>
</tr>
<tr>
<td><strong>Factor</strong></td>
<td>73</td>
<td>26</td>
<td>24</td>
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</tbody>
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Results of “IMPROVE” re OST & imprisonment

- Only 35% of OST patients and 32% of users reported never having been in prison.
- Average number of prison terms was 2.8 for patients and 4 for users.
- Prison terms: 86% for patients and 70% for users were drug-related.
- Average total duration of imprisonment was 3.2 (patients) and 4.6 years (users).
- OST was received by 23% of patients and 35% of users.
- Undergoing OST at the time of their imprisonment, 70% had to stop treatment when they entered prison.

Study „IMPROVE“ – akzept 2010
Evidence-Based Treatment: OST in Prisons

- Risk, 'intravenous drug use' – Reduction: 55–75% (1)
- Risk, 'needle sharing' – Reduction: 47–73% (1)

(1) Larney, S.: Does opioid substitution treatment in prisons reduce injecting-related HIV risk behaviours? A systematic review – Addiction 105, 216–223
Figure 14.2: Provision of substitution/maintenance treatment (OST) in the community and availability of OST programmes in the prison system in 2007 in the EU (expert rating)

OST provision in the community:
- Full
- Extensive
- Limited
- Rare
- Not available

OST availability in the prison system:
- Not available
- Rare
- Limited
- Extensive
- Full

## Monitoring harm reduction in European Prisons: Dublin Declaration

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Opioid Substitution Treatment in Custodial Settings
A Practical Guide

Editorial Group

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David Marteau (Offender Health, London/United Kingdom)
Lars Møller (WHO Regional Office for Europe, Copenhagen/DK)
Jan Palmer (Clinical Substance Misuse Lead, Offender Health London/United Kingdom)
Ambros Uchtenhagen (Zürich/Switzerland)
Caren Weilandt (WIAD, Bonn/Germany)
Nat Wright (HMP Leeds/United Kingdom)
OST Treatment Considerations - Prisons

- Ultimate goal: thoroughcare and continuation of OST
- Detoxification: if the patient is incarcerated in a prison without any access to OST
- In prisons: OST as Directly Observed Therapy (DOT), ideally with the substance of preference
- Pre-release: uptake of OST and continuation after release by community doctor
- Post-release: continuation resp. re-introduction of OST
Conclusions OST & Prisons

- Prisons must recognise consensus on the role and efficacy of OST and other evidence-measured interventions – equivalence principle
- Close connection between prison and community health care services
- Health care standards and clear guidelines on the basis of evidence-based knowledge
- Prison health can substantially contribute to crime reduction.
General Conclusions

- Need for expansion
- “Lean” treatment conditions
- Solving problems at interfaces
- Smooth continuation – throughcare in and out of custodial settings
- Psycho-social care voluntarily
- Involving more doctors
- Improving knowledge about advantages and disadvantages of medications
Contact

Further Informations under:

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www.isff.de
www.archido.de
Contents

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Buprenorphine

- Safer medication re: overdose & deaths
- Not associated with stigma of methadone
- Different approaches to BPN implementation
  - Minimal regulation (e.g. France, Malaysia)
  - Moderate regulation (e.g. USA)
  - Major regulation (e.g. Australia)
Minimal regulation models of BPN

“It’s treatment Jim, but not as we know it”

France
Malaysia, Singapore
French expansion of treatment

- Increased availability of BPN & methadone from 1995
  - Methadone restricted to specialist services
  - BPN available in primary care settings & specialist settings

- Marked expansion in numbers of OST
  - ~100,000 patients receive prescription for BPN
  - ~20,000 receive prescription for methadone

- Reasonable uptake by general health system
  - 25% of GPs have prescribed BPN, although only ~10% long term follow up > 1 patient (Mancini et al 2003)
Delivering BPN treatment in France

- No training required for doctors/pharmacists
  - Most GPs had no training in treating drug users
- No national clinical guidelines (product label only)
- No registration of patients with doctors
  - Hence patients can attend multiple doctors for scripts
- Limited capacity for supervised dispensing at pharmacies
  - Generally weekly/bi-weekly/monthly dispensing
- Limited access to psycho-social services in primary care
- ‘Complex patients’ to be referred to specialist centres
Outcomes in French system

- Marked expansion in treatment numbers – easy access
- Marked reduction in drug-related mortality since mid-1990s
- Marked reduction in HIV rates in IDUs
- Other treatment outcomes for patients appear satisfactory (although difficult to compare to other systems)
Concerns with early French system

- Prescriptions not the same as treatment?
  - Continuity of care? - ¼ patients not linked to service providers
  - Capacity for psycho-social services?

- Widespread misuse of BPN
  - 10–30% of BPN patients report regular injecting
  - 20–30% of NSEP clients report BPN as main drug injected (Obadia et al 2000)

- High levels of BZD co-prescription (40–50% patients)
  - Suggesting poor training/expertise of clinicians
Buprenorphine abuse: injecting

- BPN (like all opioids) is subject to abuse by injecting
- Epidemiological data indicates BPN injecting linked to
  - Erratic/poor availability of other opioids (e.g. heroin, OST)
  - Low levels of supervised dosing
  - Small doses of BPN prescribed
  - Poor clinician training/guidelines
  - Local cultural variations
- Harms associated with BPN injecting
  - Localised injecting problems (abscesses, thrombosis, etc..)
  - Rare: respiratory depression & death if combined with sedatives
  - Rare: systemic fungal infections, cytolytic hepatitis
  - Bad reputation for treatment
Summary of minimal regulation model

- Marked expansion in OST availability accomplished by introduction of a (poorly regulated) treatment system
  - Malaysia: 0 to 12,000 in 4 years
- Significant public health gains (mortality & HIV rates)
- But, concerns regarding availability of ‘comprehensive’ treatment programs & misuse of medications
- Can result in loss of political support
  - Singapore: 0 to 4,000 in 4 years ...and back to 0 in the 5th year