Zurich, September 2013

Medications and Recovery:

Promoting a more recovery-orientated approach; balancing aspiration with caution

Professor John Strang

National Addiction Centre, London, UK

Thanks to Ambros and colleagues

Thanks to Ambros and colleagues

BJPsych | The British Journal of Psychiatry
1–9. doi: 10.1192/bjp.bp.112.111583

Cost-effectiveness of injectable opioid treatment *v.* oral methadone for chronic heroin addiction

Sarah Byford, Barbara Barrett, Nicola Metrebian, Teodora Groshkova, Maria Cary, Vikki Charles, Nicholas Lintzeris and John Strang

Background
Despite evidence of the effectiveness of injectable opioid treatment compared with oral methadone for chronic heroin addiction, the additional cost of injectable treatment is considerable, and cost-effectiveness uncertain.

Aims
To compare the cost-effectiveness of supervised injectable heroin and injectable methadone with optimised oral methadone for chronic refractory heroin addiction.

Method
Multisite, open-label, randomised controlled trial. Outcomes were assessed in terms of quality-adjusted life-years (QALYs). Economic perspective included health, social services and criminal justice resources.

Results
addiction. The choice between supervised injectable heroin and injectable methadone is less clear. There is currently evidence to suggest superior effectiveness of injectable heroin but at a cost that policy makers may find unacceptable. Future research should consider the use of decision analytic techniques to model expected costs and benefits of the treatments over the longer term.

Declaration of interest
J.S. and N.L. have contributed to UK National Treatment Agency for Substance Misuse and Department of Health guidelines on the role of injectable prescribing in the management of opiate addiction (2003; chaired by J.S.). J.S. has chaired the broader-scope pan-UK working group preparing the 2007 Orange Guidelines for the UK Departments of Health, providing guidance on management and treatment of drug dependence and misuse. J.S. has

Declaration (personal & institutional)

- DH, NTA, Home Office, NACD, EMCDDA, WHO, UNODC, NIDA
- NHS provider (community & in-patient); also Phoenix House, Lifeline, Clouds House, KCA (Kent Council on Addictions)
- Reckitt-Benckiser, Schering-Plough, Genus-Britannia, Napp, Titan, Martindale, Catalent, Auralis, Lundbeck, Astra-Zeneca, UCB, Fidelity, Rusan, Mundipharma, Lannacher, Alkermes, Lightlake & others
- UKDPC (UK Drug Policy Commission), SSA (Society for the Study of Addiction); and two Masters degrees (taught MSc and IPAS)
- Work also with several charities (and received support) including Action on Addiction, also J Paul Getty Charitable Trust (JPGT) and Pilgrim Trust
- Support from Universitat Zurich for attending this event

My ‘personal CV’

- I’m a doctor and a scientist
- My generation has been devastated – by addiction, and by associated hazards
- Alleviating the suffering of people affected by addiction problems
- Anything that works (but only if it really works)
- No loyalty, total loyalty

Structure of today’s talk

- Personalising treatment
- ‘Full recovery’
- Remembering the evidence base
- Making good better
- Understanding recovery: positives and negatives
- Balancing aspiration with precaution

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Personalising treatment (1)

- People - all shapes and sizes
- Different constellations of needs
- I am not you; you are not me
- Today is not yesterday, nor tomorrow

Personalising treatment (2)

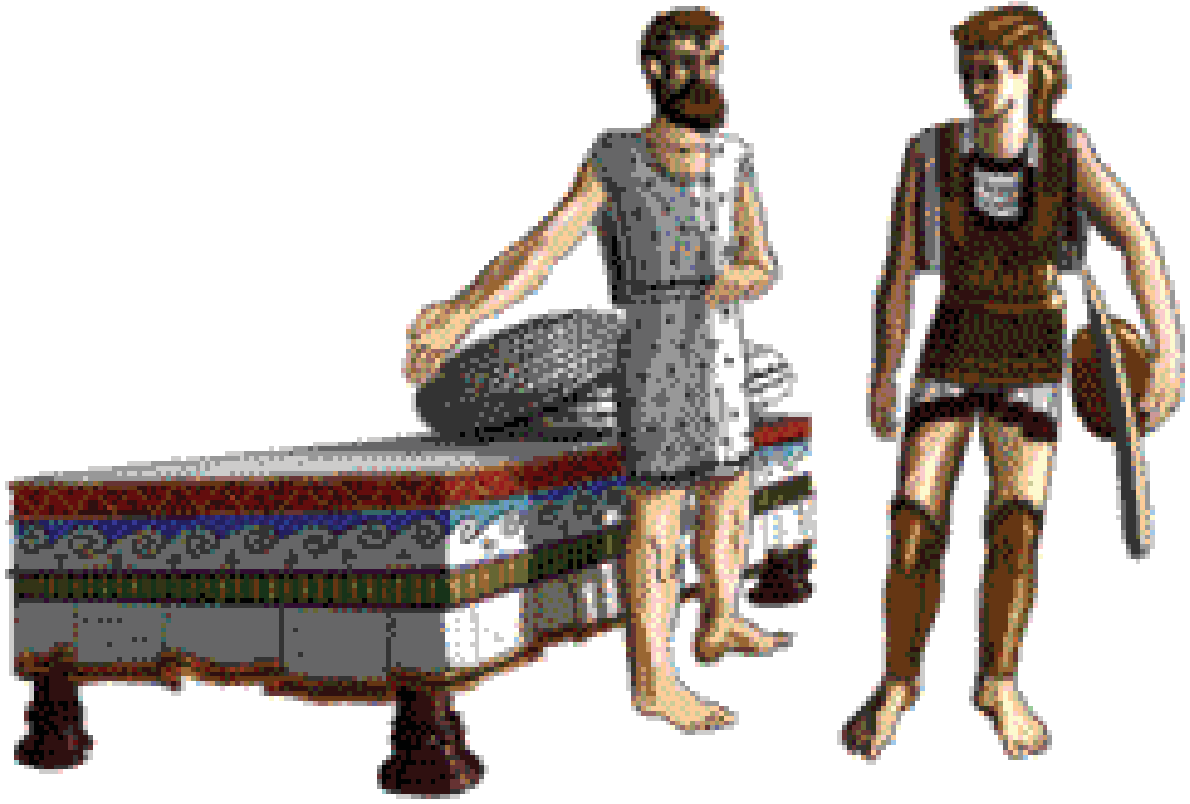
- Personally relevant and maximally influential
- Need to personalise the approach – we must not behave like Procrustes

Greek mythology - Procrustes

Procrustes was a robber of Attica, who placed all who fell into his hands upon an iron bed. If they were longer than the bed, he cut off the redundant part; if shorter, he stretched them till they fitted it.

[Any attempt to reduce men to one standard, one way of thinking, or one way of acting, is called placing them on Procrustes' bed].

Strang, J (1985) Breaking Out of Procrustes' Bed – Services for Problem Drug Takers, Psychiatric Bulletin, 9: 150-152.



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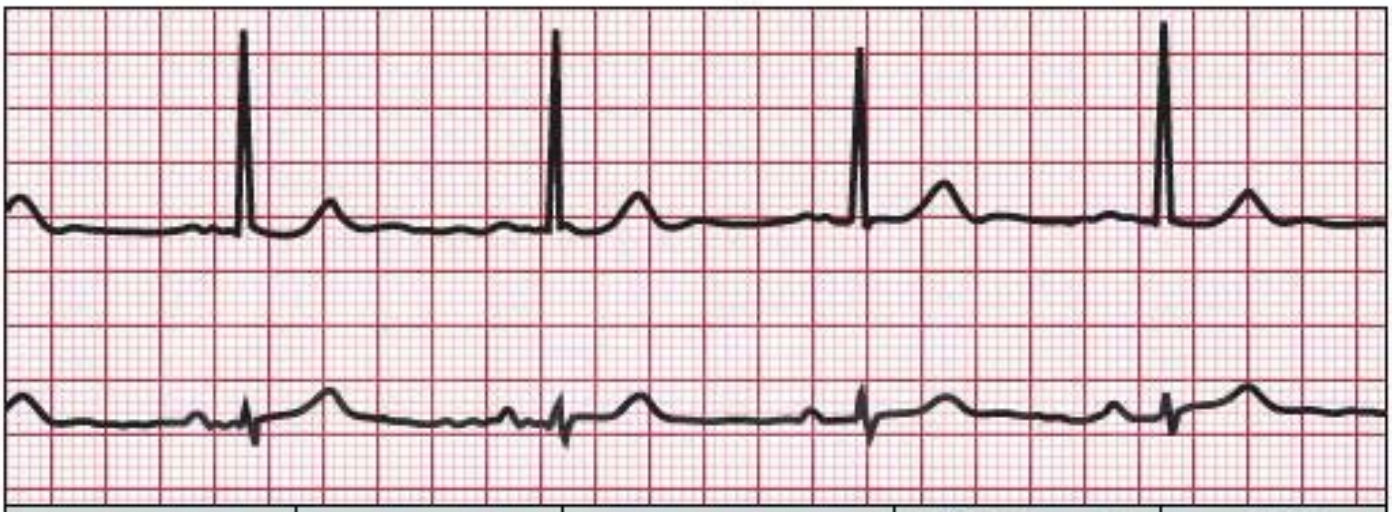
Damage from politicisation

- Cycles of hostility to OST (with confusion, mis-reporting and politicisation?)
- Assertion that OST means 'parked on maintenance'
- Criticism of all OST? Or of 'care-less' OST?

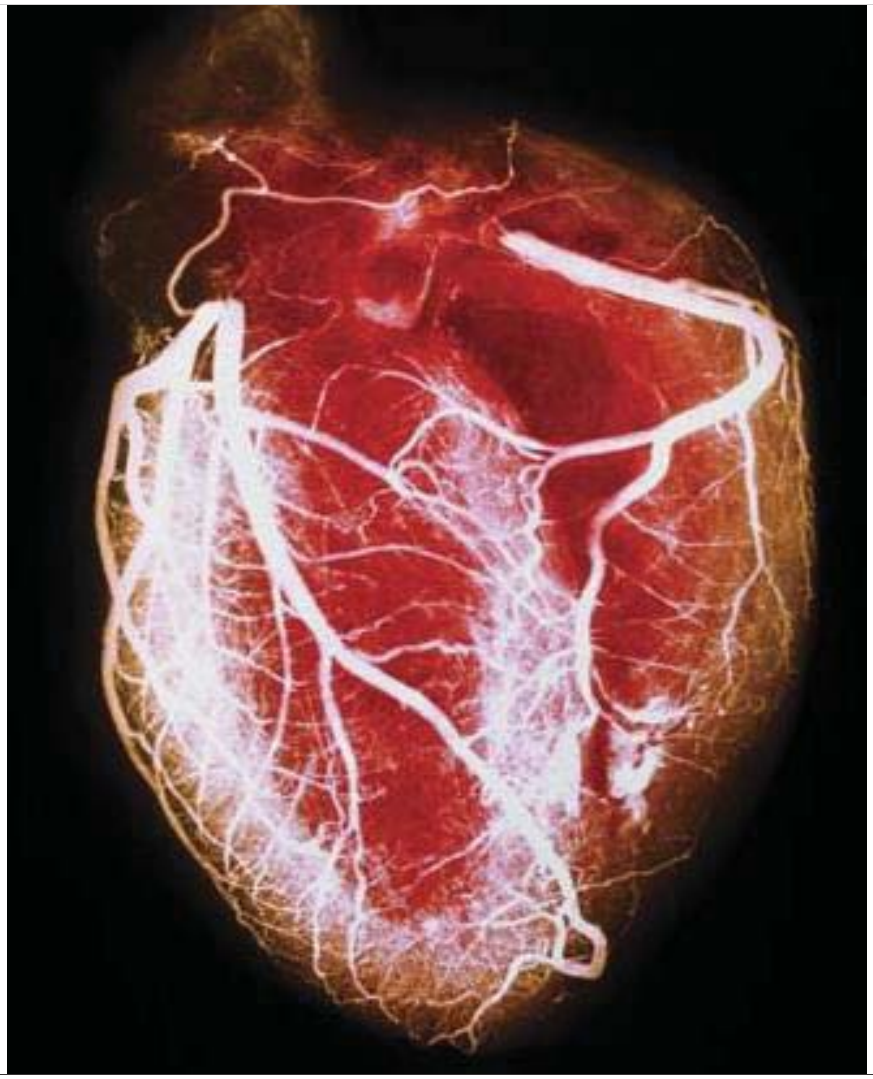
Issues in the UK (esp 2010 onwards)

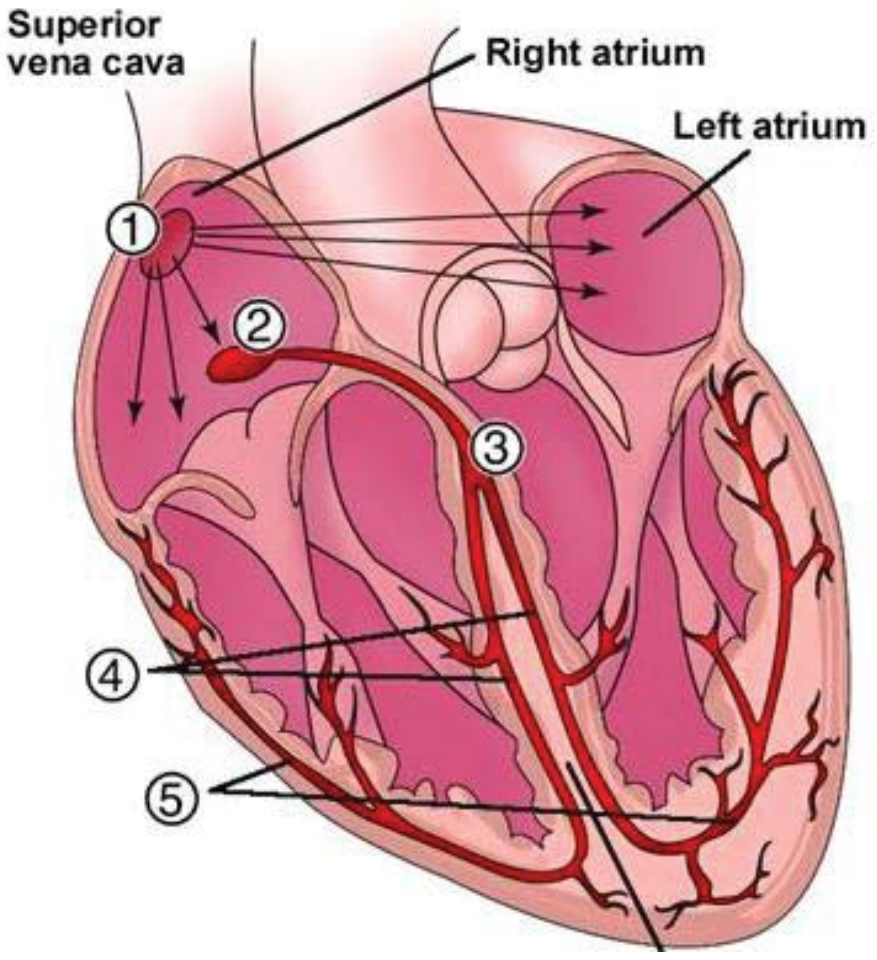
- Current debate about ‘recovery’ (heat > light)
- ‘Full recovery’ – what does this mean?
- I am personally in recovery

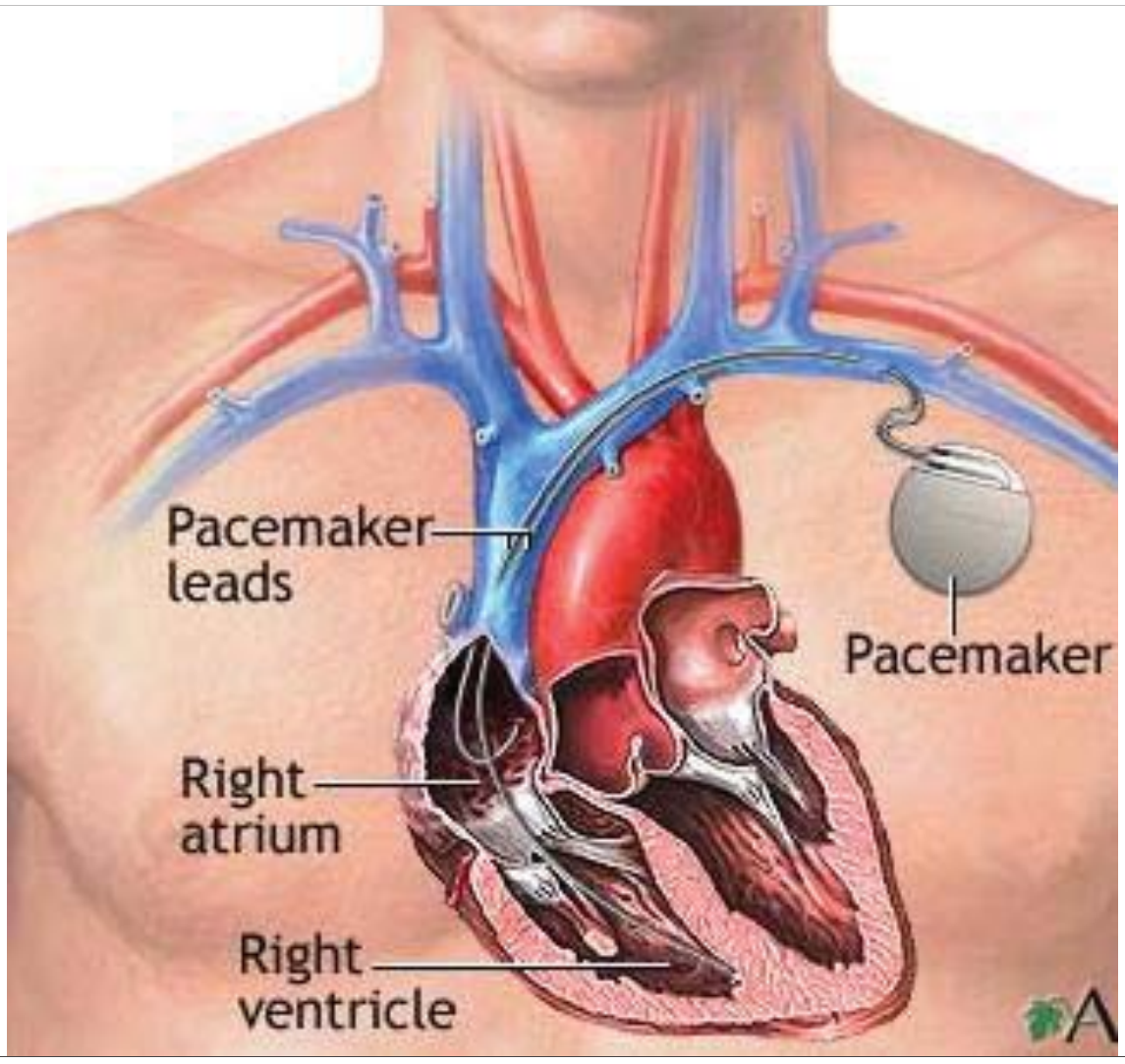
Sinus Bradycardia



Heart Rate	Rhythm	P Wave	PR interval (in seconds)	QRS (in seconds)
< 60 bpm	Regular	Before each QRS, identical	.12 to .20	<.12




Superior
vena cava
Right atrium
Left atrium
1
2
3
4
5


Pacemaker leads
Pacemaker
Right atrium
Right ventricle

Taking action to disarm addiction

KING'S College LONDON

Action on Addiction

Professor John Strang, Head of the Kings College London Addictions Department, is climbing Mount Roraima, one of the extraordinary Tepui mountains in South America, to raise money for Action on Addiction.

This is the only UK charity working across the addiction field in prevention, treatment, research, professional education and family support.

Professor Strang will double the value of donations from friends and colleagues! So whatever you kindly donate, will be subsequently matched.

www.justgiving.com/John-Strang0

John Strang is fundraising for Action on Addiction

http://www.justgiving.com/John-Strang0

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Page owner
John Strang

Climbing Mount Roraima for Addiction! And doubling your donation! UPDATE - MADE IT! (see below)

251%

£2,518.33
raised of £1,000.00
target

35
donations

Donate

My story

Thanks for taking the time to visit my JustGiving page...

I have committed to climb Mount Roraima, one of the extraordinary tepui mountains in South America. I have also committed to double the value of donations from friends and colleagues! So whatever you kindly donate, I will subsequently match. UPDATE - MADE IT! (For background, see below; also

My charity

Action on Addiction

Action on Addiction
Charity Registration No. 1117988

Addiction is the biggest preventable killer in the UK. We take action to disarm addiction. We do this through research, treatment, family support, education and training.


RORAIMA TEPUI
KUKENÁN TEPUI
Sta. Elena
Campamento base
La Escalera
Dento Falls
La Ciudadela
Kama Falls
La Laja
Parai-Tepuy
Yuruani Falls
San Francisco de Yuruani
San Ignacio de Yuruani
LA GRAN SABANA
Uruyen
Kavac
Guayaraca
Kamarata
Churún Falls
Cortina Falls
AUYÁN TEPUI
Jimmy Angel's Landing Site
Kerepacupai River
Ahonda chasm
Ahonda Canyon
Ratoncito Camp
Wall of a Thousand Columns
Devil's Canyon
Orchid Island
Canaima Lagoon Tourist Camp


RORAIMA TEPUI
Sta. Elen
Campamento base
Parai-Tepuy
Yuruani Falls
La Laja
San Francisco de Yuruani
San Ignacio de Yuruani
SABANA

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- Understanding recovery: positives and negatives
- Balancing aspiration with precaution

the cochrane library

Methadone maintenance at different dosages for opioid dependence (Review)

Faggiano F, Vigna-Taglianti F, Versino E, Lemma P

THE COCHRANE COLLABORATION®

England/UK: NICE publications

NICE technology appraisals on methadone and buprenorphine (TA114)
NICE clinical guideline: 'Drug misuse: psychosocial interventions' (CG51)
NICE technology appraisals on naltrexone (TA115)
NICE clinical guideline: 'Drug misuse: opioid detoxification' (CG52)

Health Technology Assessment 2007; Vol. 11: No. 9

Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation

M Connock, A Juarez-Garcia, S Jowett,
E Frew, Z Liu, RJ Taylor, A Fry-Smith, E Day,
N Lintzeris, T Roberts, A Burls and RS Taylor

CG51 Drug misuse: psychosocial interventions: NICE guideline - Microsoft Internet Explorer

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- Proposed optimal practice review topics
- Interventional procedures
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NICE guidance by topic

NICE guidance by date

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CG51 Drug misuse: psychosocial interventions: NICE guideline
25 July 2007
(239.1Kb 01min 23sec @ 28.8Kbps)

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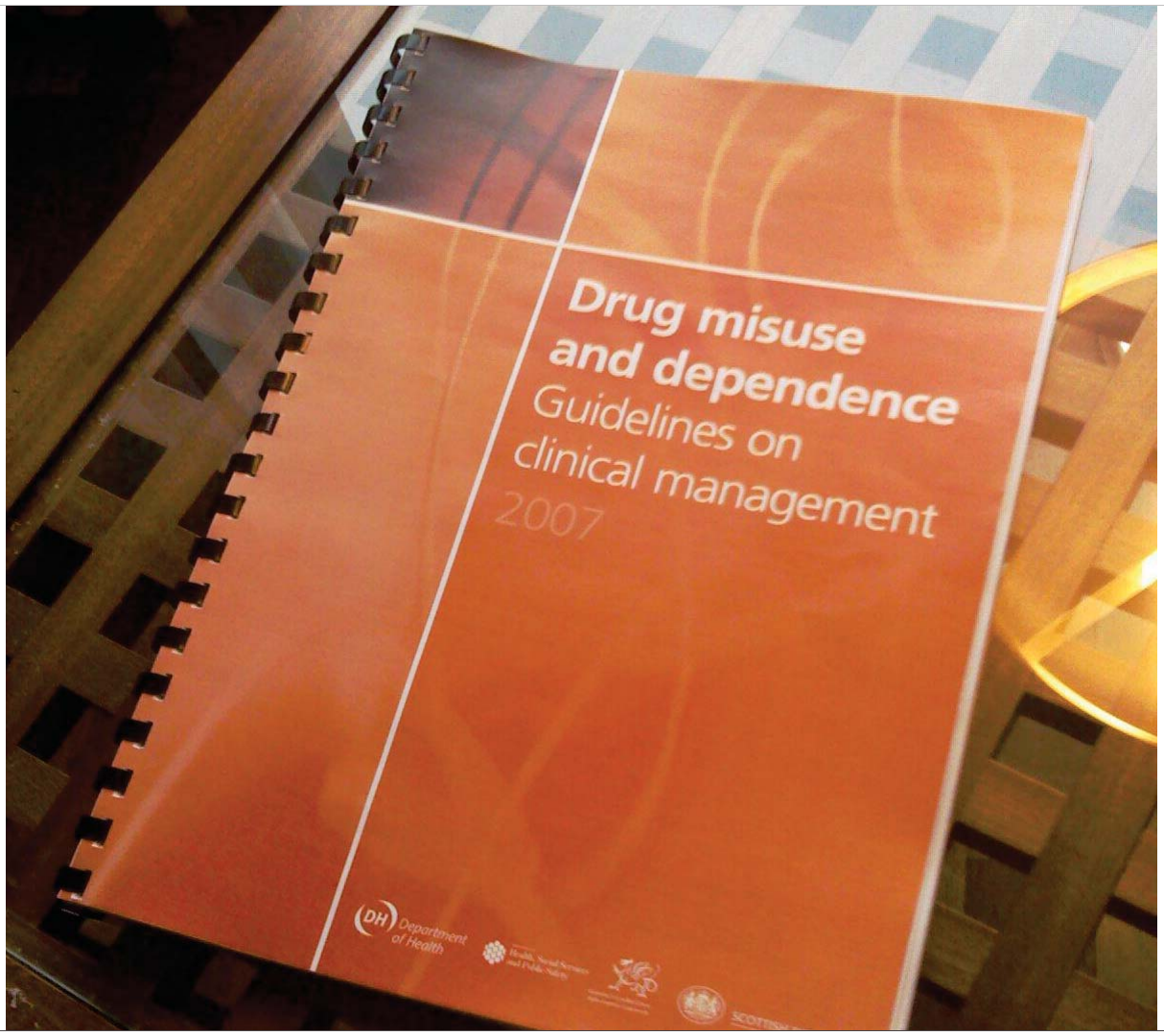
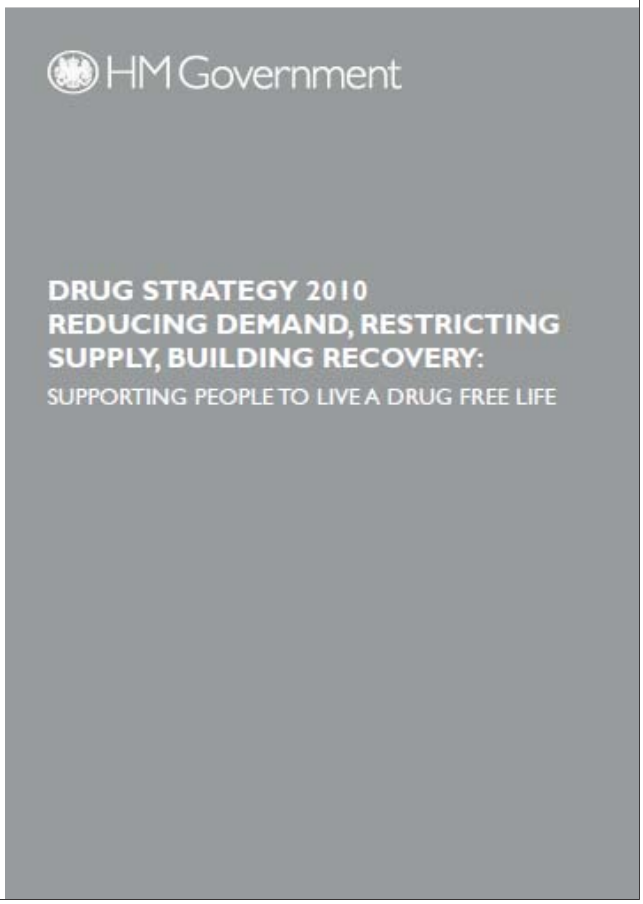


The national policy context

- 2010 drug strategy:

- *"Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification. Medically-assisted recovery can, and does, happen. ...*

- *However, for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there. This must change."*



"The task of the Recovery Orientated Drug Treatment Expert Group has been to describe how to meet the ambition of the Drug Strategy 2010 to help more heroin users to recover and break free of dependence..."

MEDICATIONS IN RECOVERY
RE-ORIENTATING DRUG DEPENDENCE TREATMENT

NHS
National Treatment Agency for Substance Misuse

Published July 2012

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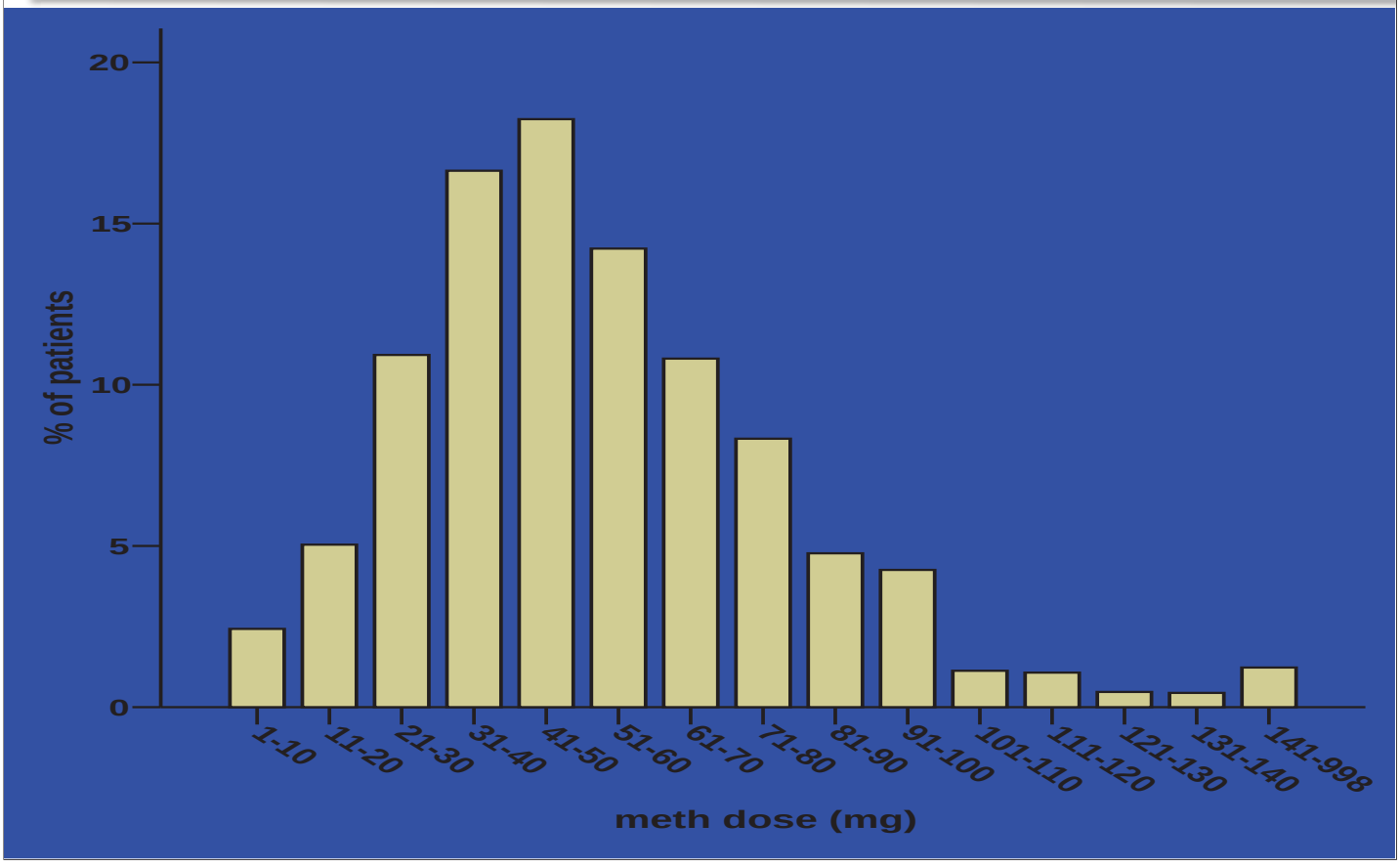
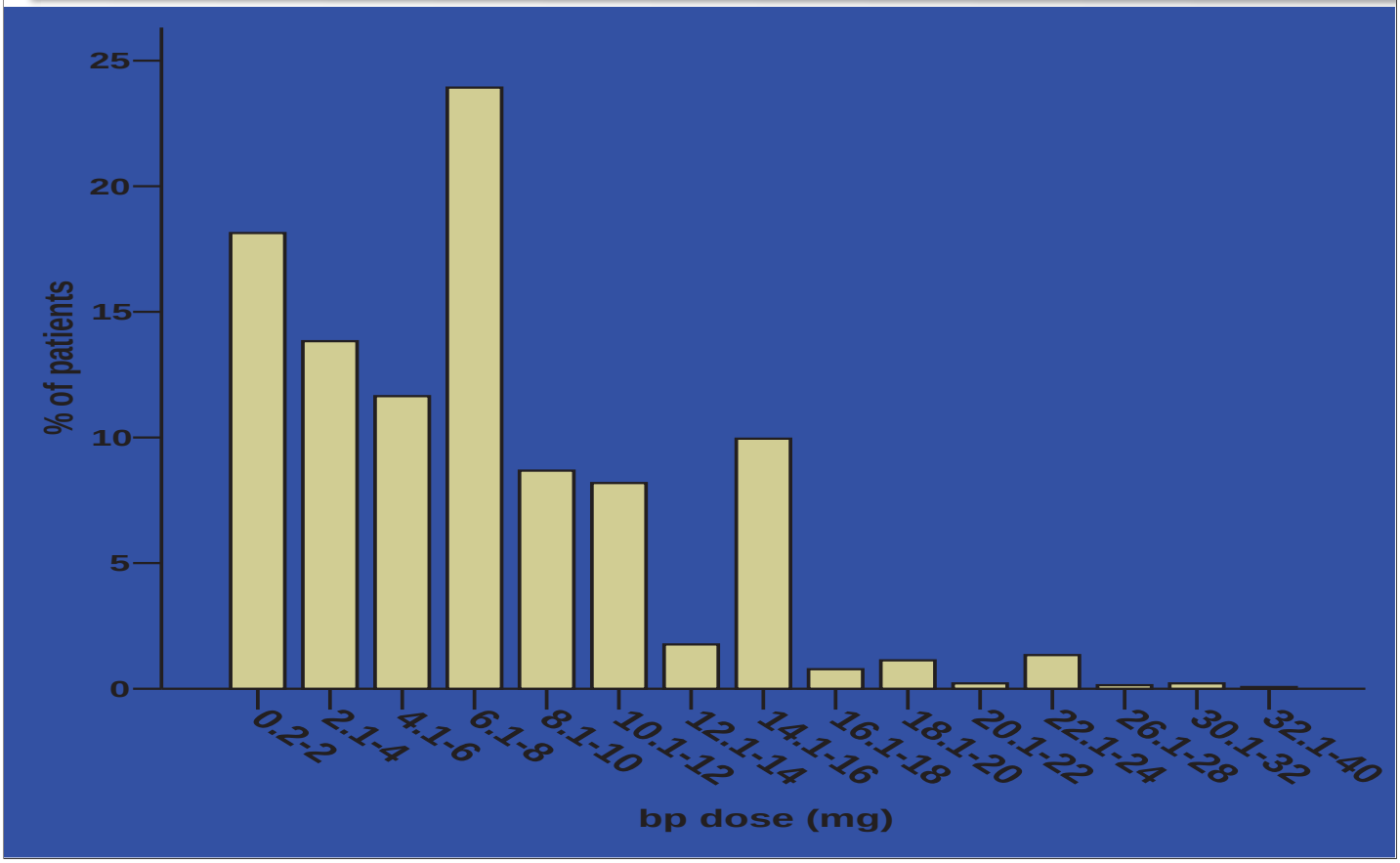
methadone daily dose -2005



buprenorphine daily dose - 2005



Within/outside recommended dose range: 1995 and 2005

	1995	2005
• Methadone* (60-120mg)	27.5%	40.1%
• Buprenorphine** (8-16 mg)	-	53.0%

* Orange guidelines, 1999 ** RCGP, 2003

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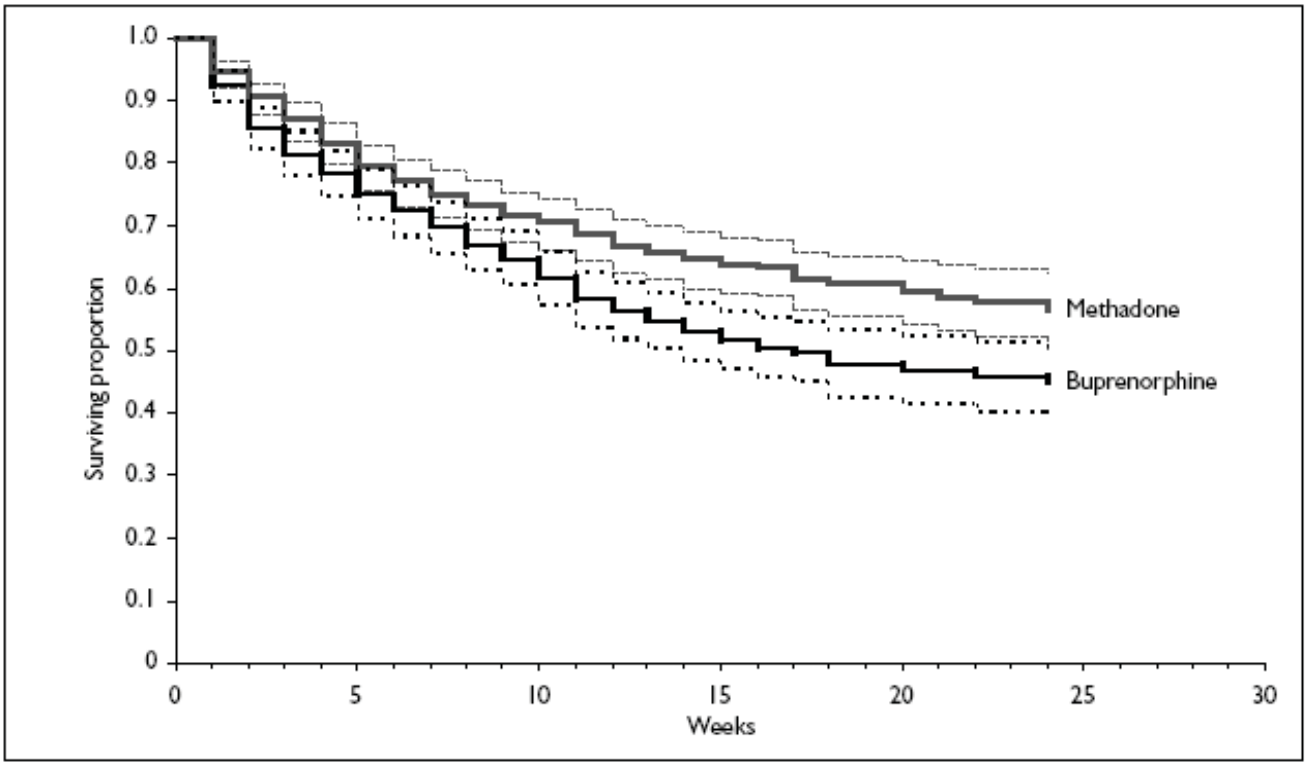
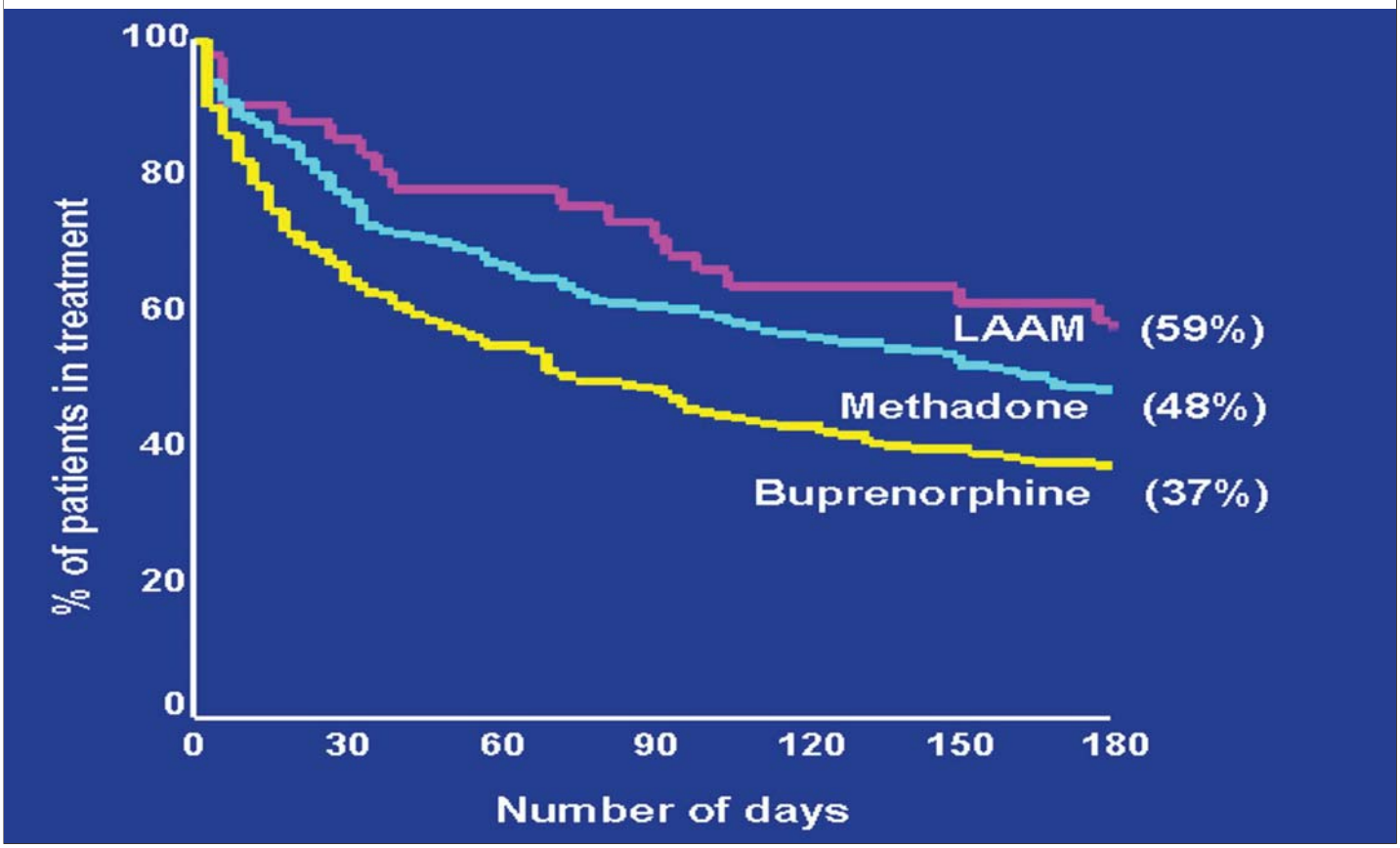


FIGURE 5 *Patient retention with MMT and BMT with flexible dosing (incomplete lines represent approximate 95% confidence intervals)*

Retention in treatment: methadone, buprenorphine, LAAM maintenance



Levels of Treatment in Methadone Maintenance Programs

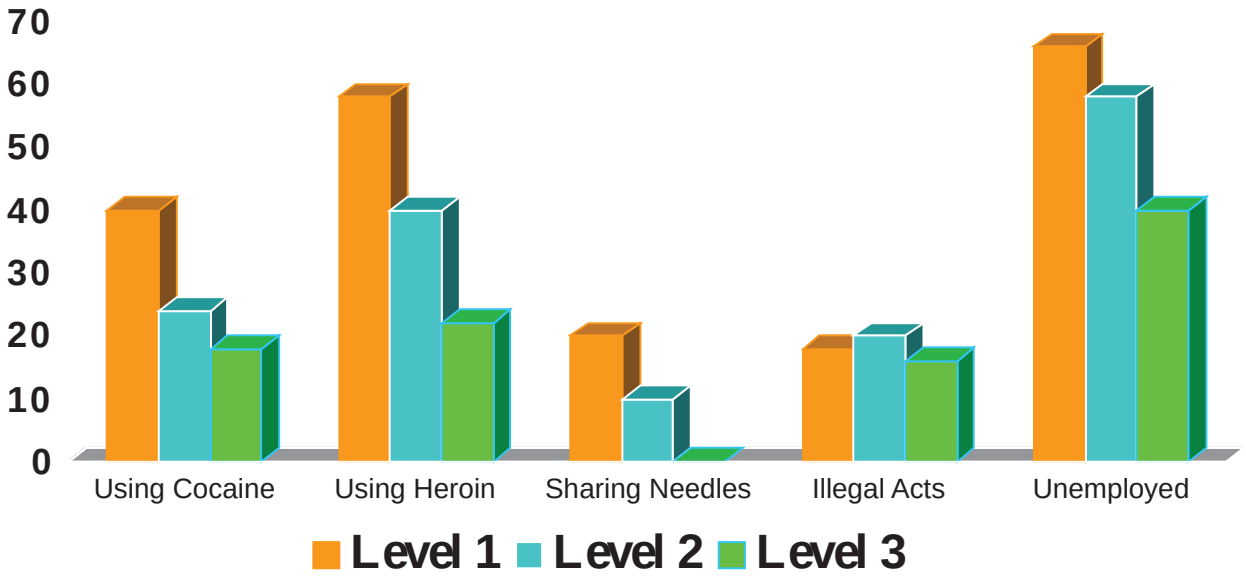
Random Assignment — Outcome at 6 Months

	Level 1	*Level 2*	*Level 3*
Methadone:	**> 65mg**	**>65mg**	**>65mg**
Counseling:		**Regular**	**Regular**
Other Services			**Employment** **Family Therapy** **Psychiatric Care**

Treatment Research Institute - McLellan, Kraft et al

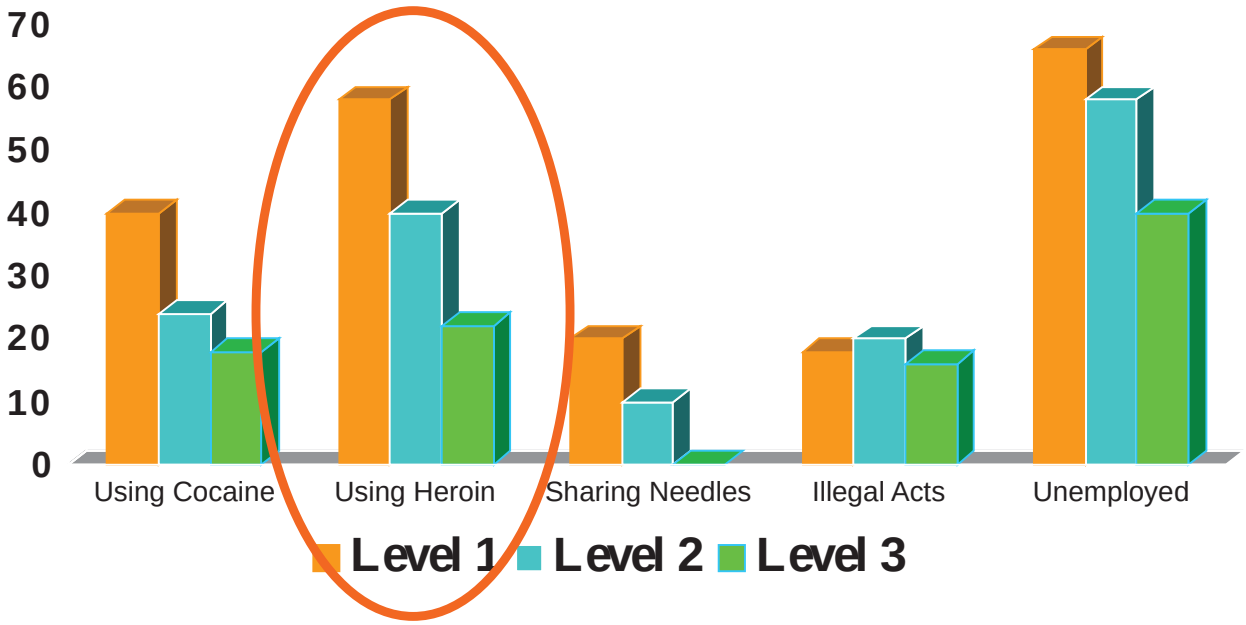
Levels of care Study

Target behaviours at 6 months



Levels of care Study

Target behaviours at 6 months



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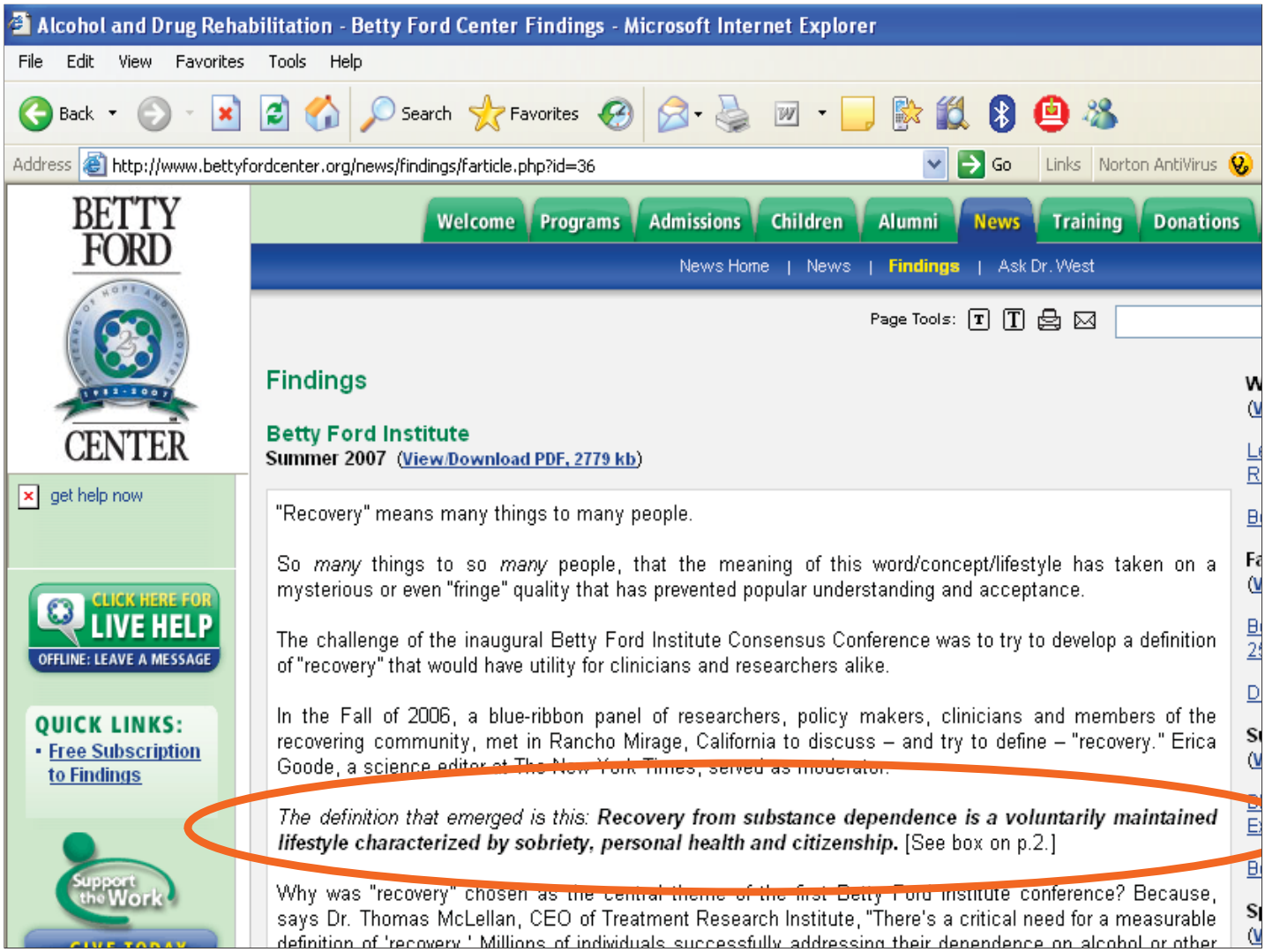
Acknowledging …

- Bill White & Tom McLellan (JSAT paper - Betty Ford Foundation initiative)
- UKDPC Recovery initiative
- English DH "Medications in Recovery" Report of the Recovery-Orientated Drug Treatment (RODT) Expert Group



William White's particular contribution

As William White has commented:

"How recovery is defined has consequences, and denying medically and socially stabilized methadone patients the status of recovery is a particularly stigmatizing consequence".

RECOVERY-ORIENTED METHADONE MAINTENANCE

William L. White, MA

Lisa Mojer-Torres, JD

Great Lakes Addiction Technology Transfer Center

Philadelphia Department of Behavioral Health and Mental Retardation Services

Northeast Addiction Technology Transfer Center

UK Drug Policy Commission (UKDPC) Recovery statement

The process of recovery is characterised by voluntarily sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society.

UKDPC Recovery statement

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UKDPC Recovery statement

The process of recovery is characterised by voluntarily sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society.

Where that takes us (1)

- Treatment retention is not recovery
- Abstinence is not recovery
- ‘Medication-assisted recovery’ – different types of medication (and many more to come)
- The power of the evidence-base of MMT/BMT maintenance; and the danger of complacency
- Recovery importantly is also to do with positives

Where that takes us (2)

- The responsibility to move up a gear
- The challenge – operationalise, implement
- Need for improvement agenda, driving quality care

"The task of the Recovery Orientated Drug Treatment Expert Group has been to describe how to meet the ambition of the Drug Strategy 2010 to help more heroin users to recover and break free of dependence..."

MEDICATIONS IN RECOVERY

RE-ORIENTATING DRUG DEPENDENCE TREATMENT

The group's final report – July 2012

- Heroin is often silent, and particularly 'sticky'
- OST is important part of high-quality treatment and can substantially improve health and wellbeing
- For the right patient at the right time, OST can be heath-conferring, recovery-enabling and life-saving
- Bad OST or wrongly-applied OST can do harm
- Leaving treatment might be individually important but treatment termination isn't recovery
- Degrees of recovery – realistic aspirations
- Some people recover fast, some slow – but all need recovery support
- Done right, OST is effective but it should be viewed as a platform for recovery
- Don't end it too early: premature OST termination is hazardous
- OST termination carries risks: clinicians and agencies have responsibilities – increased case monitoring, extra support, 'safety net' planning and resources

"The task of the Recovery Orientated Drug Treatment Expert Group has been to describe how to meet the ambition of the Drug Strategy 2010 to help more heroin users to recover and break free of dependence..."

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NHS National Treatment Agency for Substance Misuse

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Conclusion: challenges and concerns

- (i) institutional inertia, (ii) therapeutic complacency (iii) pursuit of cheapness
- Aspiration in time of austerity – challenge for individuals; challenge for practitioners & agencies
- Be prepared – ‘safety net’ planning to stabilise ‘stumbling’ and capture during ‘fall’

Assessing benefit achieved

- Measure (i) change since baseline (i.e. before treatment) and (ii) change since last review.
- N.B. Benefit gained might be the prevention of an anticipated deterioration (more difficult to identify).
- Not only reduced negatives but also increased positives (i.e. what is added to one’s life as well as what is being removed).

The status of medications, psychological and social support (1)

- The taking of prescribed medication is neither essentially good nor bad. (Put it to one side, whilst assessing well-being).
- The assessment of benefit received should be exactly that – requiring examination of benefit accrued during, and presumed to be as a result of, treatment/rehab/etc.
- A similar ‘putting-aside’ of the patient’s reliance on continued non-medication treatments/therapy; and of reliance on support from family, community and self-help support systems.

The status of medications, psychological and social support (2)

- ‘Putting-aside’ does not mean that the matter of medications and other interventions are not reviewed. Dose ‘fit’ and adherence/compliance must be measured. Good adherence/compliance may be vital; while for others treatment may no longer be necessary.
- The clinician must make an individually considered clinical judgement whether (i) to maintain current treatment ISQ (in status quo); (ii) to modify current treatment to make more efficacious; (iii) to review alternative options.
- IMO, this is fundamental to the application of good clinical personalized medicine.

Thank you