TWIST Training With Stakeholders
Applying EU Addiction Research

Treating problem drug use

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Harm reduction versus recovery/rehabilitation ?

Conflicting goals ?

- Historically - “strict” vs “liberal” treatment programs
- Example: Opioid maintenance treatment (OMT) –
  high versus low threshold
- Could harm reduction and social rehabilitation and recovery both be goals within the same program ?
- Experiences from the Norwegian OMT program

Review

Opioid substitution therapy: Lowering the treatment thresholds

Georgios Kourounis[a,b], Brian David Wensley Richards[a,b], Evdokia Kyprianou[c], Eva Symeonidou[c], Minerva-Melpomeni Malliori[d], Lampros Samartzis[a,b,*]

Table 1
Qualitative characteristics of high threshold and low threshold treatment designs as our classification of treatment barriers.

Qualitative characteristics		High threshold treatment design	Low treatment threshold design
Treatment accessibility barriers	Waiting lists	Long	Short or absent
	Admission criteria	Inflexible	Flexible
	Point of access	Strictly specialist care	General practitioners and office based care
	Cost of treatment	Cost to patient	No cost to patient
Treatment design barriers	Treatment design	Universally the same for all patient groups	Individualized according to the patient
	Medication options	Standard and limited	Flexible and pluralistic
	Duration of treatment	Limited	Unlimited
	Relapse policies	Zero tolerance approach	Relapses expected and treated as part of the OST
	Drug administration	Supervised only	Take-home therapies
	Adjuvant psychological treatment	Obligatory	Voluntary or absent

Drug and Alcohol Dependence, 2016

Treatment accessibility barriers

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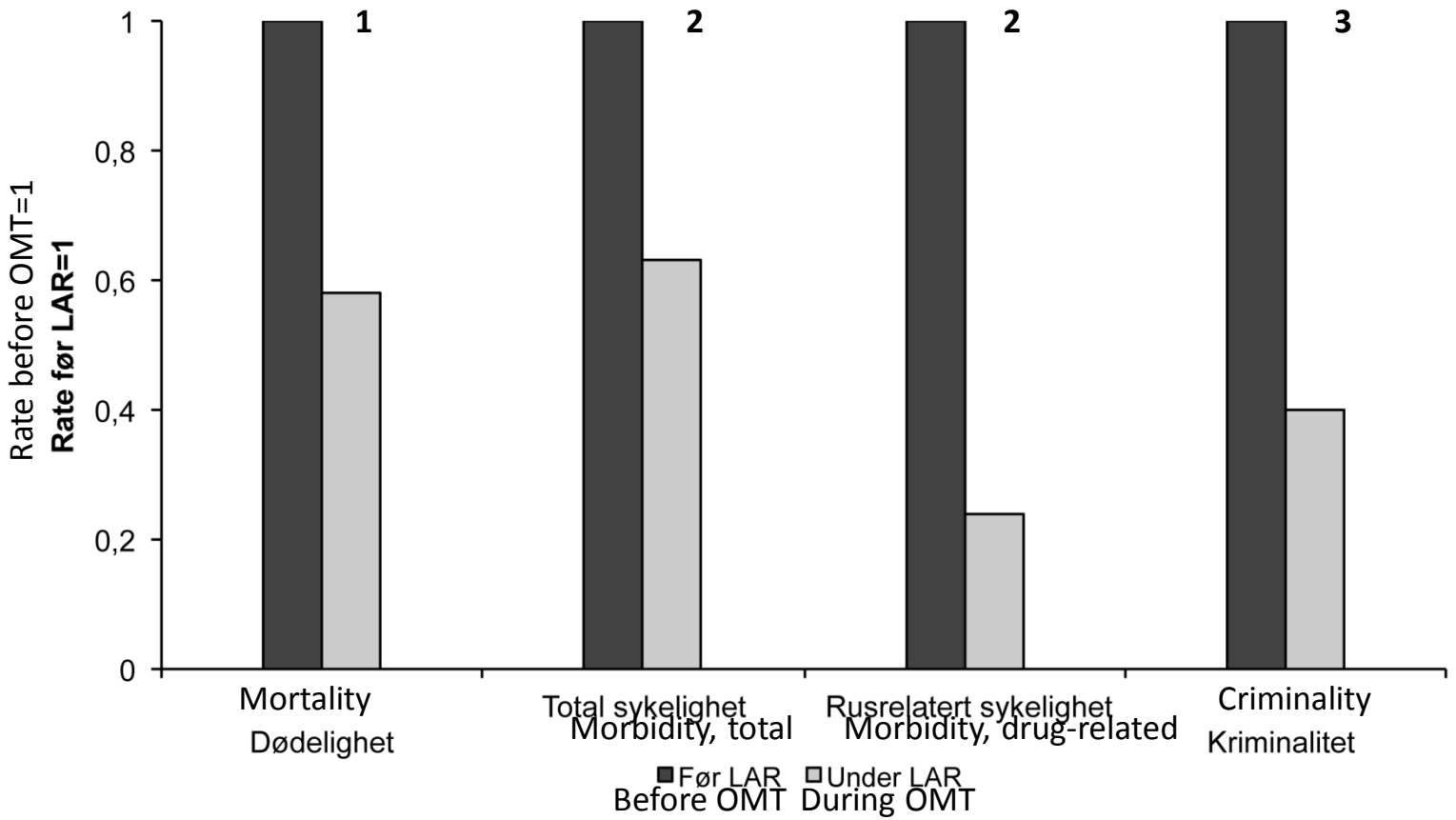
Experiences from the Norwegian OMT program

- From an initially rather strict high threshold model (1998) gradually to a model combining harm-reduction and rehabilitation within the same program (mainly low threshold)

- OMT guidelines 2010: The goal: to “achieve the optimal level of function” (and not “abstinence”) – which means an individualized treatment program
  - different goals for different patients
  - differnt goals for the patient over time

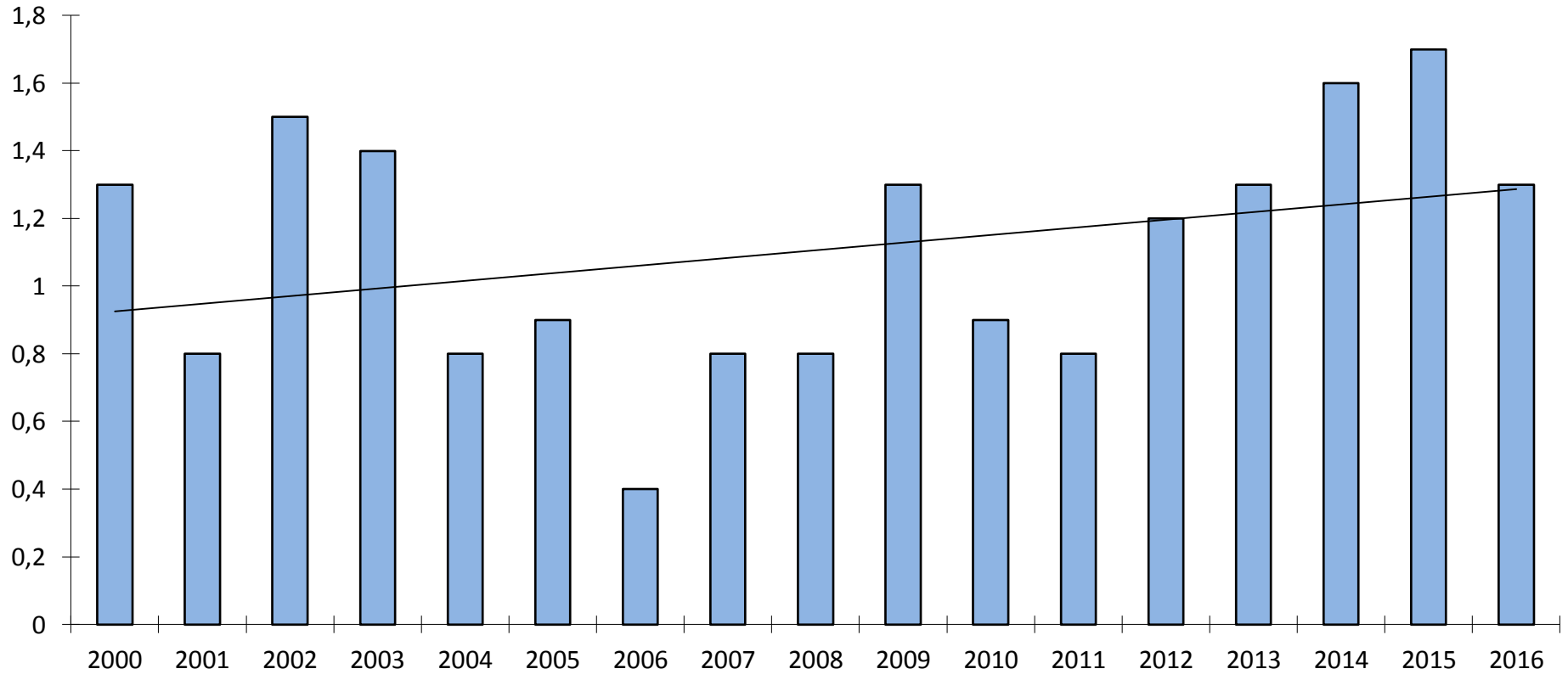
- What are the consequenses ?

Mortality, morbidity and criminality - before versus during OMT (cohort studies Norway)



1 Clausen et al. 2008
2 Skeie et al. 2011
3 Bukten et al 2011

Death rate OMT Norway
2000 – 2016, deaths per 100 PY



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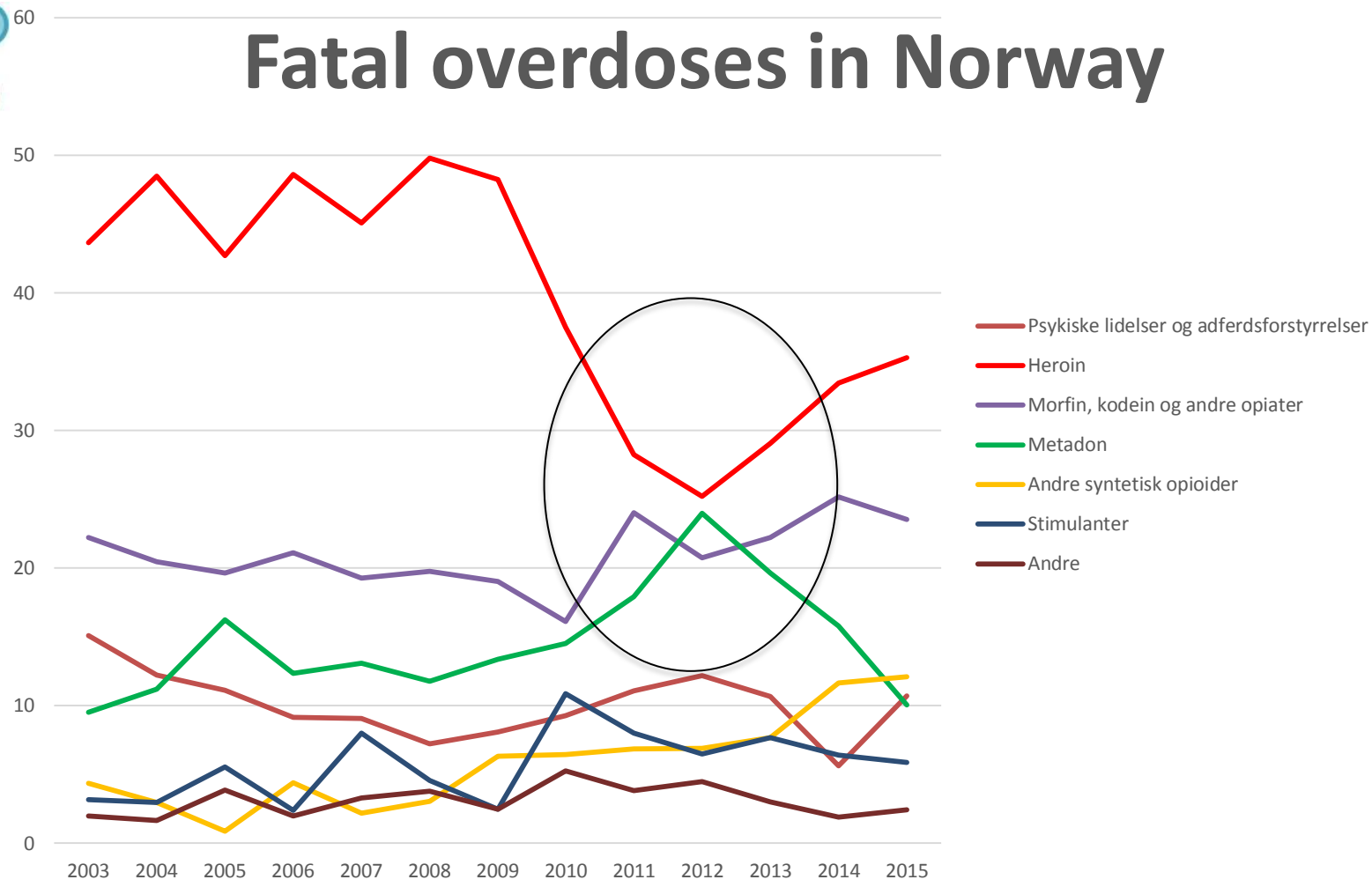
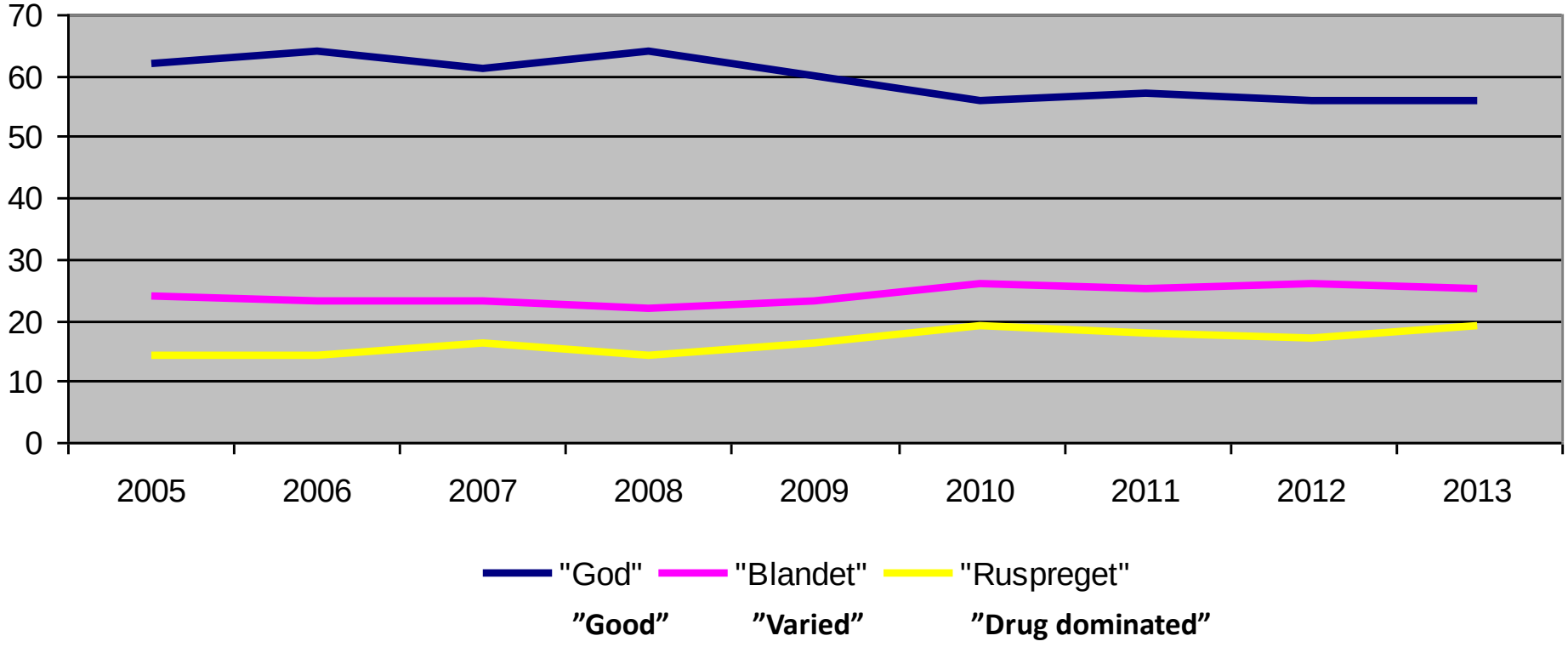
Fatal overdoses in Norway



From Ellen Amundsen, Norwegian Institute of Public Health, 2016

Drug use last 4 weeks, 2005 – 2013, per cent



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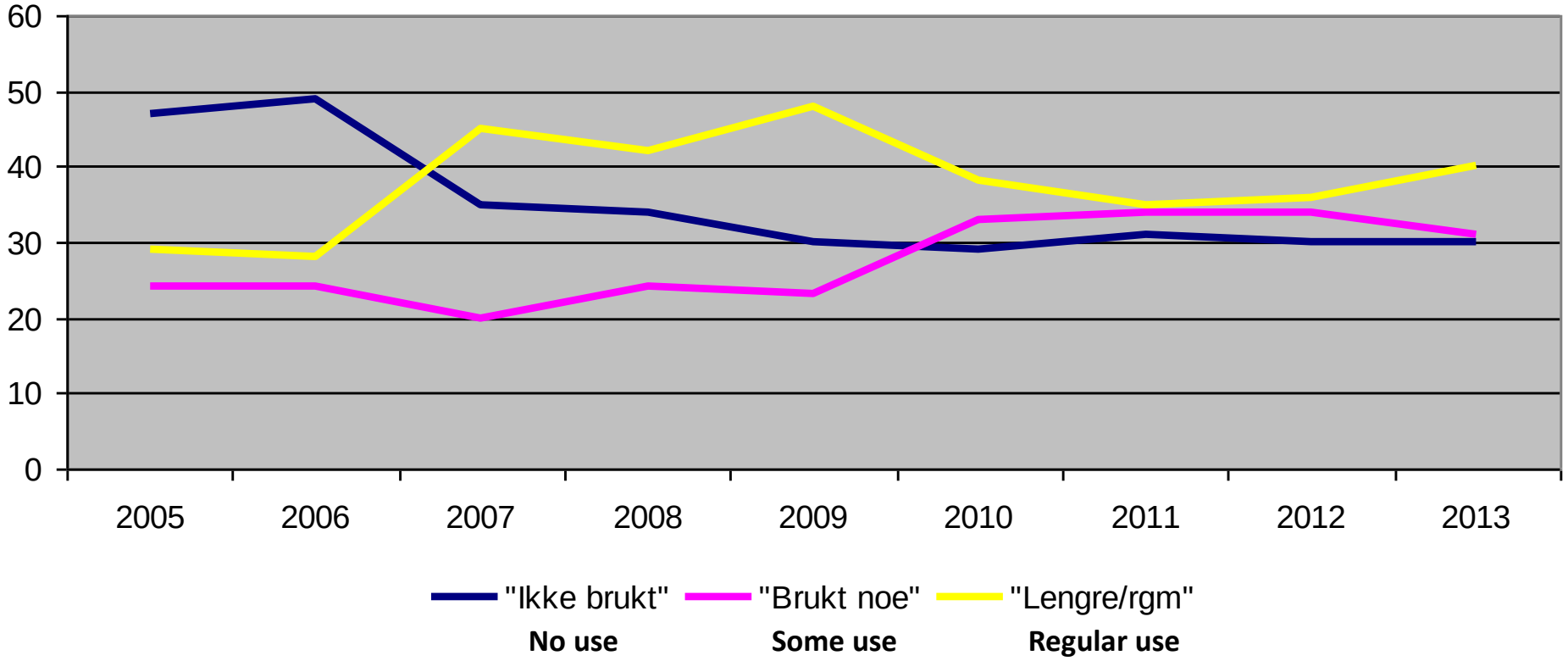
Drug use last year, 2005 – 2013, per cent



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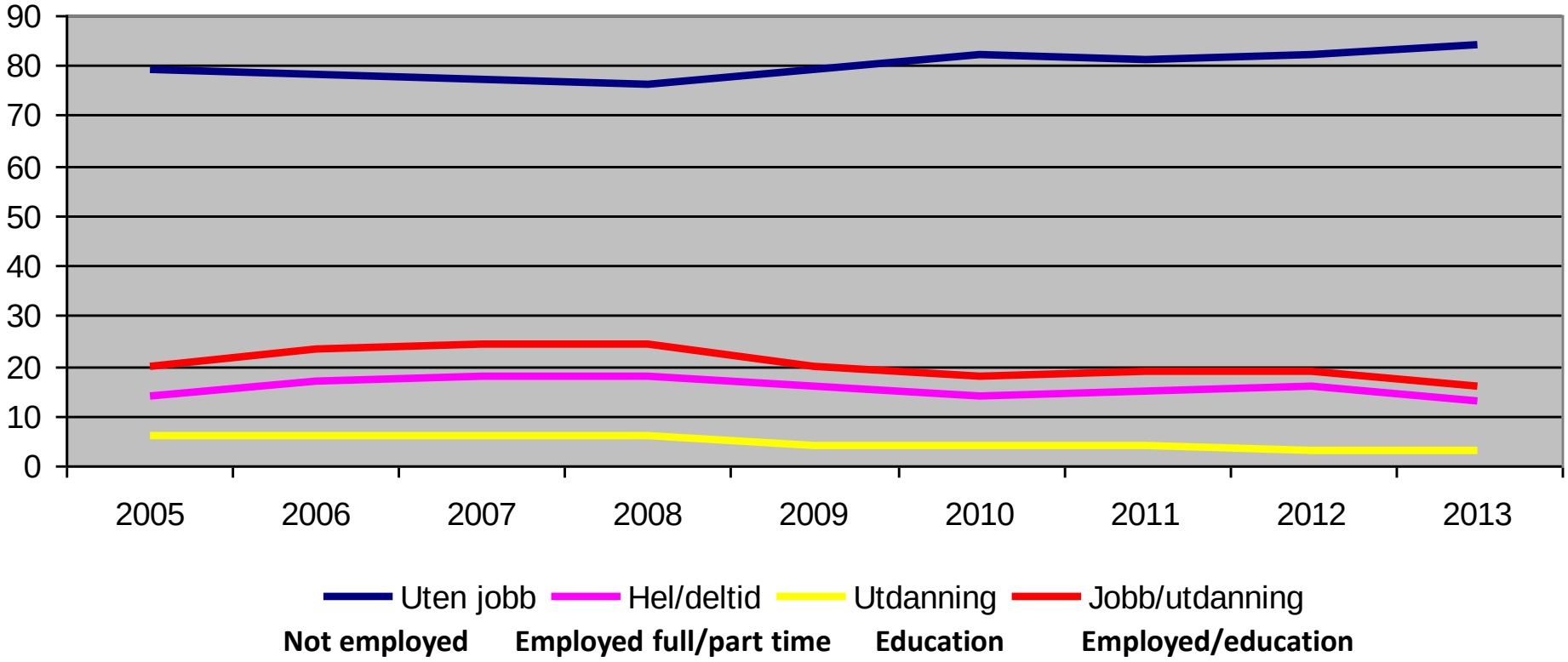
Employment 2005 – 2013, per cent



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OMT in Norway – what is achieved and what are the challenges ?

Keeping patients in OMT (retention in treatment)	Very high !
Coverage of target group	Around 50 % - system thresholds ?
Unintended side effects – diversion of medication	Some – the right “strict/liberal balance” ?
Treatment of comorbidities	Rather good – but room for improvement ?
Social rehabilitation	Varying – definitely room for improvement !

Question for discussion

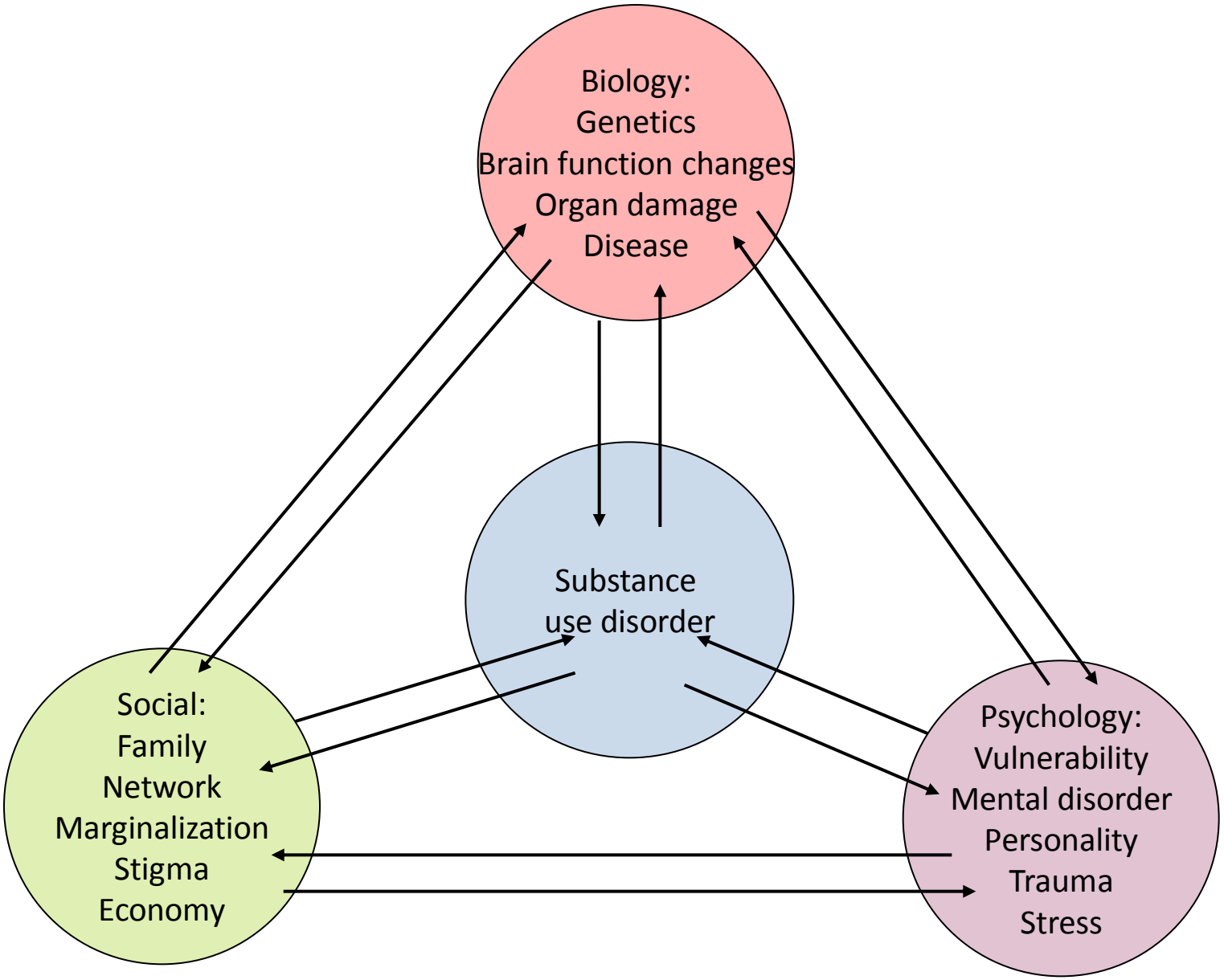
Is it possible to combine different goals – harm reduction versus recovery and social rehabilitation – in the treatment of problem drug use?

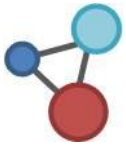
Comorbidity

The relation between problem drug use and concurrent mental and physical health problems

The problem drug use syndrome

- Severe problem drug use – a bio-psycho-social syndrome
- The substance use disorder is the defining core of the syndrome
- Additional and interwoven mental and physical health problems (often severe)
- All within a marginalized and problematic social context


Biology:
Genetics
Brain function changes
Organ damage
Disease
Substance
use disorder
Social:
Family
Network
Marginalization
Stigma
Economy
Psychology:
Vulnerability
Mental disorder
Personality
Trauma
Stress



Complex phenomena are above all

characterized by their complexity …

No quick fix …

Psychiatric comorbidity – Lifetime prevalence and odds ratios

Kessler USA 1994

Group	SUD %	SUD OR	Alcohol %	Alcohol OR	Other substances %	Other substances OR
General population	16.7		13,5		6.1	
Schizophrenia	47.0	4.6	33.7	3.3	27.5	6.2
Mood disorders	32.0	2.6	21.8	1.9	19.4	4.7
Bipolarity	56.1	6.6	43.6	5.1	33.6	8.3
Major depression	27.2	1.9	16.5	1.3	18.0	3.8
Dysthymia	31.7	2.4	20.9	1.7	18.9	3.9
Anxiety disorders	23.7	1.7	17.9	1.5	11.9	2.5
OCD (compulsion)	32.8	2.5	24.0	2.1	18.4	3.7
Phobia	22.9	1.6	17.3	1.4	11.2	2.2
Panic disorder	35.9	2.9	28.7	2.6	16.7	3.2

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Somatic comorbidity

- The burden of disease caused by SUD (Degenhardt 2013)
- Reduced life expectancy
- Chronic diseases occuring earlier in life
- Physiological age exceeds chronological age
- Social marginalization

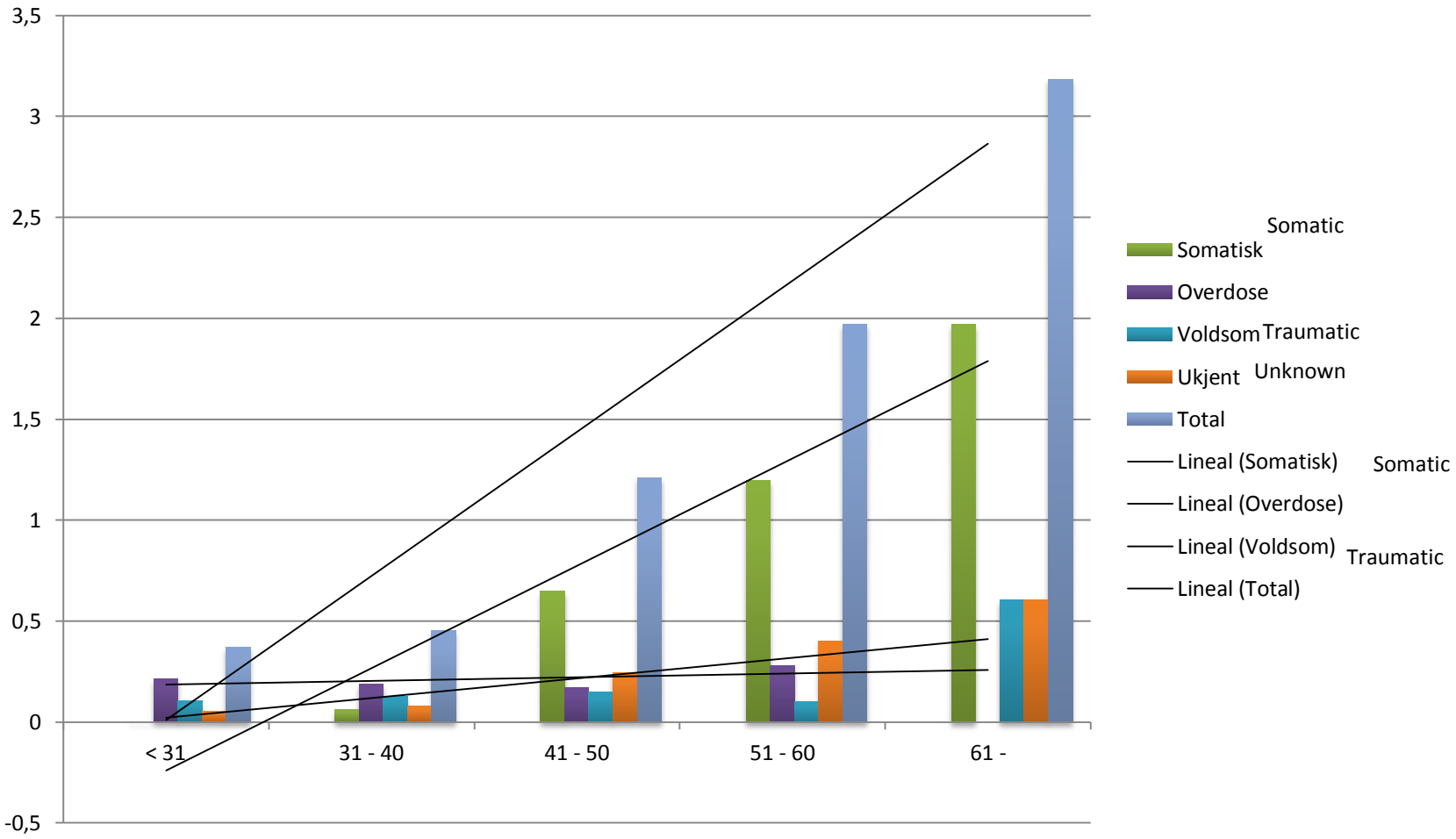
Somatic comorbidity – risk factors related to problem drug use

- Factors indirectly related to problem drug use
  - social deprivation (poverty, housing, criminality, trauma, stress …)
  - nutrition
  - smoking
  - lack of adequate physical activity
  - increased level of mental disorders (independent risk factor)
  - insufficient treatment of chronical diseases
- Factors directly related to drugs and route of administration
  - **overdose** and complications to non-fatal overdose
  - health risks related to non-medical **injecting** (HIV, Hepatitis B, Hepatitis C, bacterial infections, increased overdose risk, thromboembolism…]
  - increased risk of violence, suicide and accidents

Age and OMT

	Systematic review 2011 (Degenhardt L et al, 2011)	OMT - Norway 2014 - 2015
Overdose	47	20
Traumatic deaths	27	15
Somatic diseases	26	64

Increasing age – causes of death Norwegian OMT program 2014-2016 (preliminary results)



Status reports Norwegian Centre for Addiction Research 2014 - 2016

How can health conditions be improved ?

- OMT programs for all opioid dependent persons who want it
- Access to general health services (GPs …) and follow-up of ordinary chronic diseases (cardiovascular, diabetes, respiratory…)
- Low threshold reach-out health services
- Access to advanced medical treatment (HIV, Hepatitis C, severe infections …)
- Access to specialized psychiatric treatment
- Increased focus on somatic morbidity within SUD treatment programs
- Reducing stigma and prejudiced attitudes in the health care services
- Promote lifestyle changes (nutrition, smoking, alcohol, exercise…)

How can health conditions be improved ?

What do you think can be done to reduce concurrent psychiatric and somatic morbidity among problem drug users?

Thank you!

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Applying EU Addiction Research

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