Opioid dependence, a life-threatening condition, is preventable

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Opioid dependence presentations are frequently late, typically between 2 and 10 years duration of untreated illness. Other associated and preventable chronic life-shortening conditions are usually acquired. Costs of acquired illnesses, obstructed potential, and social consequences are high.

Treatment (opioid substitution) is effective but treatment episodes are often longer than the original period of uncontrolled dependence. And although effective, treatment has its own complications: the “side-effects” of dispensing controls and stigma.

Deering et al in this issue of the Journal are circumspect about the 40 year report card for opioid substitution in New Zealand (NZ)—a “needs to do better” assessment. Many of the themes from the 20 year report remain: access difficulties, primary care integration, stigma. Even tempered with some optimism for buprenorphine specifically, this is a disappointingly slow trajectory.

The opioid-dependent typically have to face the bitter reality that short-term attempts to withdraw from opioids—to “detox”—are unlikely to be successful. Wishing this was not so is not enough to change this. Relapse prevention support with naltrexone, or “addiction interruption” with ibogaine offer tantalizing hope, but as yet without firm basis. Opioid substitution with methadone or buprenorphine remains the treatment supported by the evidence, in a class of its own by comparison with the alternatives.

Substance dependence has core qualities of compulsion to use, dyscontrol over the rate of use, salience (exclusive importance) pertaining to the use, and dysfunction arising from the use. Implementation of external controls, mainly by dispensing restriction, is a key requirement during the period that the patient has diminished internal control. Treatment is best achieved with the uniform serum levels of methadone and buprenorphine that allow single daily dosing without the on/off reinforcement of shorter-acting opioids.

With sustained treatment, frequently measured in years rather than months, perspectives develop, peers change and drug immediacy wanes. Rigid dispensing control may be justifiably relaxed to foster rehabilitation needs (employment, childcare, etc), with rehabilitation frequently providing the necessary resilience to allow successful treatment exit.

Compulsion, dyscontrol, salience, dysfunction. These are not easily measured in vivo. It is unclear how well specialist opioid providers assess these, perhaps poorly in many cases. Surveys of NZ’s lower North Island clients indicate that if decisions to allow loosened dispensing were based on perceived risk of self-injection, then these perceptions were frequently mistaken.
Similarly, findings that methadone constitutes a significant proportion of street opioid supply in NZ, with methadone prescribing in the main limited to opioid substitution providers, suggests insufficient dispensing control.\(^6\) These factors, with waiting lists reflecting underfunding by an estimated 50\%, have been difficult to square with suggestions that more people be engaged in treatment with less dispensing restrictions.\(^1\)

Opioid substitution providers witness daily the consequences of opioid dependence. It would be unsurprising if they were sensitised to the risk of initiating new cases, with opioids derived from their prescriptions. Burdensome role conflict is inherent in the desire to believe and help individual clients while remaining wisely doubtful on behalf of protecting the public. Longstanding underfunding diminishes the time, energy and patience to sustain compassion for a population with multiple needs—a far cry from the “special incentives” to ensure the quality of treatment programmes.\(^2\)

Given these challenges, it is fortunate that younger people seem to be making drug use decisions less likely to include opioids—the opioid substitution cohort of has become progressively older. To some extent this may reflect knowledge about drug harms—with opioids, methamphetamines and nicotine increasingly seen, rationally, as the ones to avoid. While we wait for opioid substitution to tardily “come of age”, can we instead hope the current unmet and sometimes resented need for opioid substitution be consigned to history?

The “Mr Asia” prosecutions in the 1970s and 1980s dismantled the heroin supply chains into NZ. Although heroin has occasionally arrived since, its unreliable availability has limited its exposure.\(^7\) Only users within circles already abusing opioids are likely to have access, and only for discrete periods.

In the past 3 decades, nearly all NZ cases of opioid dependence have been initiated and maintained by pharmaceutical opioids. Use of opium, now more often derived from seasonal poppies or the washings from bulk poppy seeds, provides an infrequent diverting anachronism. Instead, most opioid dependence is sustained with the leading candidates of morphine or methadone, with oxycodone increasing its street market share over codeine-containing preparations.\(^6\)

The rest of the developed world has caught up. Deaths from pharmaceutical opioids in the US outweigh deaths from heroin and cocaine combined, with similar trends in Canada, Australia, and the UK.\(^8\) However, in these countries, this change in the balance of problem opioids less a result of absolute limits on heroin supply—instead this reflects the relative ease with which pharmaceutical opioids can be acquired.

In a closed economic system, constrain the supply of one value, and unmet demand will drive access to the other. Alternatively, free the availability of one, and demand for the other will decrease. NZ was successful in constraint of heroin supply to an unusual degree, probably as a result of favourable factors (island isolation, a small market place, effective enforcement, low corruption rates).\(^7\)

In retrospect, it has become clear this had left the country with two choices: maintain the closed system by providing only pharmaceutical opioids—or shrink the closed system by also reducing access to pharmaceutical opioids for aberrant use.
In reality, a third, more defeating choice has been unwittingly taken—to expand the system by putting in more pharmaceutical opioids. Portenoy and Foley’s small case series of 38 patients with heterogeneous chronic pains was extrapolated in pain management environments to promote hitherto much greater use of opioids, in longer courses and in higher doses. Courses were longer in many cases through being no longer finite—for non-malignant pain.

Although globally it is possible to read a retraction on this “opioiphilic”-prescribing, New Zealand had already invited into its system supplies of new opioids—oxycodone, codeine combinations—while simultaneously increasing its morphine prescribing (PHARMAC, unpublished data).

The benefit of prolonged courses of opioids is not assured: chronic opioids clearly cause pain in some cases. What proportion of cases is worsened by opioids is unclear: it may be that we struggle to read the evidence against the superficial logic that if opioids are effective analgesics for acute pain, they provide analgesia in chronic conditions. The few weeks of temporary relief by raising the dose provides both doctor and patient with an instant fix, artificially reinforcing this belief if there is no sustained change in function.

Yet there is no ambiguity about the harms associated with increased availability of opioids. Without adequate supervision, more opioids are used aberrantly, either in attempts to extend the analgesic effect beyond medical safe limits, or recreationally. Most people that use opioids recreationally did not have to gain the prescription first-hand.

Pain opioid users frequently resent being categorised as opioid “addicts” but find they may come to share the same core qualities. With escalating and early prescriptions, the prescriber colludes in the dyscontrol. Pain anticipation combines with the on/off effect of shorter-acting opioids to foster debilitating, relentless salience.

There is no indication that this “pain” group has different treatment needs to the “addict” group; a prolonged period with long-acting opioids combined with case support still shows best effect, irrespective of the origin of the opioid. Increasingly chronic pain opioid users have to suffer referral to struggling opioid substitution services.

The new gateway drug to opioid dependence may be the cursorily prescribed opioids. Well-meaning but naïve iatrogenic opioid supply, whether prescribed for pain or dependence, will ensure the need for opioid substitution.

Unless we achieve more prevention of opioid dependence, by collectively addressing pharmaceutical supply, we can expect to keep the 40 year old that “needs to do better”.

Competing interests: I have been present at presentations by Roche and Reckitt Benckiser and importers of Ibogaine. Reckitt Benckiser (manufacturer of Suboxone) paid for travel and attendance to a Belgium opioid substitution conference.

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References:


