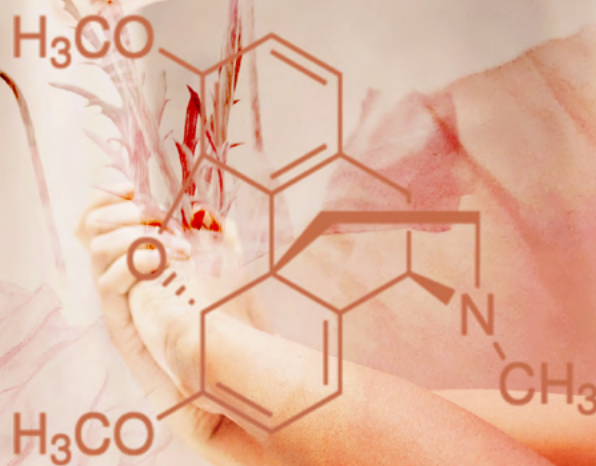
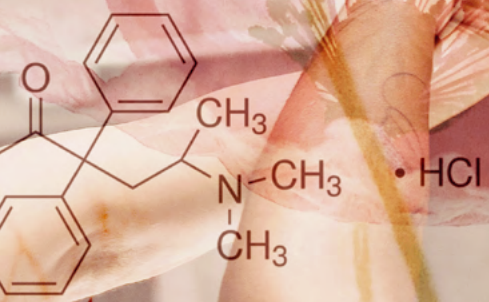
CHECK

SUBSTITUTION THERAPY





2022

"**CHECK**" is a magazine for people who use drugs, experts and advocates working in the EECA region, and those who want to learn more about the drug policy and harm reduction in the region. It is published by the Eurasian Harm Reduction Association (EHRA) and the Eurasian Network of People Who Use Drugs (ENPUD).

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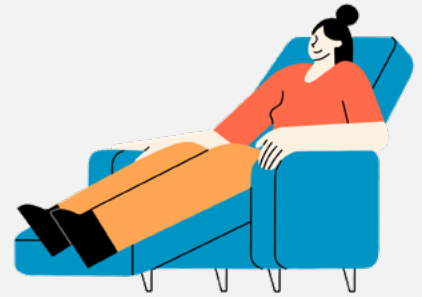
"Please be quiet. This person has taken a medicine and is having some rest."

These were the words of the doctor who greeted us on the premises of a medical heroin substitution treatment centre in Denmark in 2013. This moment came to my mind in 2021, when I entered the OST unit at home in Ukraine to get my medicine and heard a person in a white coat saying: "Here they are, running in like cockroaches." Substitution maintenance therapy has two components that are equally important and have an impact on the efficiency of the programme.



Substitution therapy provides medication that has the same effect as the substance on which the person is dependent. For people with opiate dependence, as well as for HIV-positive people, a range of medications is available so that a suitable regimen can be chosen for each person. In Berlin we met Ali, an OST patient: "I reached out for help because of my opiate dependence, in order to be prescribed methadone. After a while I realised that I kept using illegal substances. The doctor suggested that I try buprenorphine and drew up a transition plan for me. After a few months they put me on morphine. And the doctor said that if morphine did not help to reduce the number of injections, medical heroin would be prescribed." For people dependent on stimulants in the Czech Republic, a dexamphetamine programme was launched.

Maintenance therapy means acceptance, professionalism and creating a space for people to bring out the best in themselves. The treatment helps to restore physical health. And to enable us to recover psychologically, programmes in European countries provide facilities for both doctors and patients: spacious comfortable waiting and relaxation rooms; a doctor who will ask about life, about problems and help to find solutions.

In countries of our region, substitution treatment rooms often have bars and angry staff, who use our dependence to manipulate, punish or humiliate us. The staff in charge may not procure the medicine on time, leaving 300 people to suffer from withdrawal; or they set the lowest price as a condition of purchase, disregarding the quality of the medicine. They know that people are forced to put up with it until their health and social connections are restored. And they do not care that the consequences for patients include loss of health, loss of employment, loss of family relationships. Consequences for the public budget include the cost of diagnosis and treatment of new HIV and hepatitis cases, treatment or amputation of limbs, disability, and welfare payments. This is not our choice.

Wrapping up our experience exchange in Denmark, I asked the doctor: "When did you realise that the quality of the medicine and the conditions of taking it have a significant impact on the patient's well-being and reduce the risks of engaging in illicit use? " She replied sadly: "For 30 years we had tried to change people's lives to fit in with our rules, and it didn't work. Then we changed our approach and created programmes with our patients' lifestyles in mind." So, we offered them both injectable and tablet heroin twice a day; our patients receive methadone at night. We organised a relaxation room; we also have a vein detection lamp".

Recovery is difficult, especially rebuilding trust in dependence treatment services. To improve accessibility and quality of treatment, and to expand the range of medication, the Eurasian Network of People who Use Drugs created a regional Treatment Expert Council. Our task is to team up with medical professionals and specialists from Public Health Ministries, and to help set up programme conditions in line with international standards.

Olya Belyayeva
ENPUD program coordinator

SANANIM, the place of safety and support: substitution therapy programme in the Czech Republic

A tour of the centre was led by David Pešek, head of the SANANIM Contact Centre in the heart of Prague, Czech Republic.

The SANANIM harm reduction facility is open every day of the year, including weekends and holidays. Opening hours are from 9 am to 8 pm, adapted to the needs of the community. The needle exchange room is also the place where we discuss with people what they require from us that day. We make a verbal agreement about further interventions, whether it is medical treatment, addiction counselling, carrying out of sheltered employment or dispensing of OST or other medications. Our centre is visited by more than a hundred clients every day. This does not allow us to work individually with everyone, but every client has the opportunity to request individual counselling or other specialised services. Once such a partnership is initiated, a key worker or case manager is assigned to the client.

We are a small programme for the most vulnerable people that failed in other programmes, and we mainly offer buprenorphine and methylphenidate as OST medication. Our limit is twenty people. Every client that is in the OST programme has his/her own case manager. Medication is dispensed on a daily basis, and we work collaboratively to address social, relational, legal and other issues related to the client's situation. It is up to the client and the agreement to determine what serves and works best. Somebody is coming every day; somebody has a take-home dose for one week. Clients in conflict with the law can do community service at our centre.

It is also possible to employ clients in sheltered employment. The centre's address serves as a contact address for homeless people; they can also store medicine such as ART at our place if needed.

We have a shower in the facility. It can be used by people, but as there is so much rush and we have only one and are pretty much over capacity, it is usually mainly for people that need medical assistance and take a shower before the medical procedure (for example, skin defects on legs, abscesses, etc.). Another important reason to use a shower is for women and their special needs.

The multidisciplinary team is composed of addictologists, psychologists, psychiatrists, medics, social workers, ex-users, peers and other helping professionals. This makes it possible to reach the whole spectrum of needs according to the biopsychosocial and eco-spiritual model. We also provide group sociotherapeutic activities, such as art therapy or Sunday movie screenings. There is also an open therapy group every Tuesday. Most of these services take place in the contact room. An important part of our work is also the ability to refer clients to other appropriate services or treatment facilities. We can accompany clients to these services if necessary or initiate a tripartite collaboration and continue the case management.

We try to be a safe shelter – or even home for a while – for the most vulnerable people on the streets of Prague, a place where people can have nice relations, rest a little and take a break from their busy lives.

4. THE THERAPEUTIC ROOM

6. THE OFFICE

3. THE COUNSELLING ROOM

5. THE CLINICAL ROOM

2. THE CONTACT ROOM/ MEETING ROOM

1. HARM REDUCTION EXCHANGE PLACE

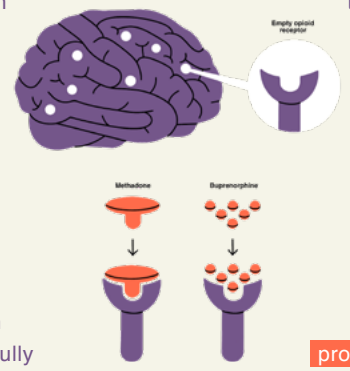
Who, when and for what reason invented opioid substitution therapy?

The prescribing of pharmaceutical heroin as a treatment for heroin dependence was established in the UK medical practice (known as the "British system") by the 1926 Rolleston Committee. The committee accepted the principle that doctors could legitimately prescribe addictive drugs as part of dependence treatment. Because of concerns regarding overprescribing and diversion to the illicit market, the Dangerous Drug Act 1967 restricted the prescribing of heroin to treat dependence to doctors holding licences from the Home Office. Nowadays, heroin-assisted treatment is available to a small subset of people with OST needs in only a handful of countries (e.g., Switzerland, the Netherlands, Germany, Canada and the UK).

Methadone was developed in Germany before World War II and was initially used as a pain medication and analgesic. In 1949, researchers in Lexington, Kentucky, demonstrated that methadone was the most effective medication for opioid withdrawal. In 1964, methadone maintenance began as a research project at The Rockefeller University in New York, and in 1966, initiation of treatment with methadone was transferred to outpatient facilities. Methadone-assisted treatment is nowadays available in numerous countries, but there are still many places where it is prohibited (e.g., Russia, Uzbekistan, Brazil, Nigeria and Saudi Arabia).

How does it work?

OST is used for the replacement of opioids, such as heroin, fentanyl, oxycodone, morphine and codeine. OST is not used for the substitution of non-opioid drugs. However, substitution therapy also exists for stimulant users, for example, pharmaceutically assisted treatment with methylphenidate in the Czech Republic. OST medication binds to the opioid receptors in the human body and prevents feelings of withdrawal and craving while also providing a sense of stability. It can be given as a short-term treatment to help people stop using opioids altogether or as a long-term maintenance drug. While research has demonstrated that the effectiveness of OST in polydrug users is less pronounced than in people who exclusively use opioids, it is nevertheless statistically significant; therefore, classifying polydrug use as an exclusion criterion for accessing OST is not justified.



OST medication can be either a full agonist or a mixed agonist–antagonist. Full agonist binds to the opioid receptors and fully activates them. This means that when a person uses a full agonist drug (e.g., heroin and methadone), they can fully feel the effects of the drug. On the other hand, mixed agonist–antagonist sometimes behaves like an agonist, while under different conditions, it acts as a blocker. A blocker does not activate opioid receptors and instead blocks the activity of other opioid drugs, meaning that users can't feel the effect of opioids when using them on top of blocker medication (they don't feel the "buzz"). In opioid-dependent people, using opioids on top of medication that is a partial blocker (for example, buprenorphine) also causes the emergence of withdrawal symptoms.

On the intersection of medicine & social support

OST is an evidence-based medical programme, which improves people's physical and psychological health. It helps them avoid health problems such as overdose and drug-related death, reduces illicit drug use and improves treatment retention; in case of injecting drug use, it prevents vein damage and bacterial and viral infections (HIV and hepatitis B and C). The medical programme consists of medical assessment, titration and stabilisation on OST medication, regular medical reviews, short-term detoxification and long-term maintenance treatment. Additionally, OST services often provide blood-borne viruses testing, needle and syringe programmes and—in some countries (e.g., the UK)—naloxone training and provision. When there is a clinical need for it (in dual diagnosis cases), OST should ideally be delivered in combination with mental health treatment, which is often provided by OST providers' partner organisations.

OST is also an effective social programme with numerous positive social impacts; for example, it improves social functioning (employment, housing, social relationships and family life), reduces acquisitive crime committed to support a drug habit and lowers criminal justice and social welfare costs. The social programme includes psychosocial interventions, support groups, housing support, education, training and employment programmes, family support, peer mentoring and volunteering opportunities.

MIX or DON'T MIX?

Consuming a combination of **methadone and buprenorphine** should be avoided. On the one hand, buprenorphine acts as an opioid; it increases sedation and slows down breathing. On the other hand, buprenorphine can behave as a blocker and prevent methadone from fully working, which can lead to withdrawal symptoms (i.e., precipitated withdrawal) in opioid-dependent people. Combining these medications may also reduce the analgesic effect of methadone.

Methadone and alcohol are both depressant drugs, which means they increase sedation, depress the central nervous system and slow down the heart rate and breathing. Consequently, alcohol magnifies the effects of methadone. Both alcohol and methadone prolong the QT interval (the time it takes from the heart muscle contraction to its subsequent rest), which predisposes people to serious cardiac irregularities. Mixing alcohol and methadone should be avoided because it increases the risk of overdose and death.

Low Risk & Synergy	Low Risk & No Synergy	Low Risk & Decrease	Caution	Unsafe	Dangerous

	LSD	Mushrooms	DMT	Mescaline	DOx	NBOMes	2C-x	2C-T-x	5-MeO-xxT	Cannabis	Ketamine	MXE	DXM	Nitrous	Amphetamines	MDMA	Cocaine	Caffeine	Alcohol	GHB/GBL	Opioids	Tramadol	Benzodiazepine	MAOIs	SSRIs	
LSD	LSD	↑	↑	↑	↑	↑	↑	↑	↑	⚠	↑	↑	↑	↑	⚠	↑	⚠	⊙	↓	↓	⊙	🐶	↓	↓	↓	LSD
Mushrooms	↑	Mushrooms	↑	↑	↑	↑	↑	↑	↑	⚠	↑	↑	↑	↑	⚠	↑	⚠	⊙	↓	↓	⊙	🐶	↓	↑	↓	Mushrooms
DMT	↑	↑	DMT	↑	↑	↑	↑	↑	↑	⚠	↑	↑	↑	↑	⚠	↑	⚠	⊙	↓	↓	⊙	🐶	↓	↑	↓	DMT
Mescaline	↑	↑	↑	Mescaline	⚠	⚠	⚠	⚠	⚠	⚠	↑	↑	↑	↑	⚠	↑	⚠	⊙	↓	↓	⊙	🐶	↓	⚠	↓	Mescaline
DOx	↑	↑	↑	⚠	DOx	⚠	⚠	⚠	⚠	⚠	↑	⚠	🐶	↑	🐶	⚠	🐶	⚠	↓	↓	⊙	🐶	↓	⚠	↓	DOx
NBOMes	↑	↑	↑	⚠	⚠	NBOMes	⚠	⚠	⚠	⚠	↑	⚠	🐶	↑	🐶	⚠	🐶	⚠	↓	↓	⊙	🐶	↓	⚠	↓	NBOMes
2C-x	↑	↑	↑	⚠	⚠	⚠	2C-x	⚠	⚠	⚠	↑	↑	↑	↑	⚠	↑	⚠	⊙	↓	↓	⊙	🐶	↓	⚠	↓	2C-x
2C-T-x	↑	↑	↑	⚠	⚠	⚠	⚠	2C-T-x	⚠	⚠	↑	⚠	🐶	↑	🐶	⚠	🐶	⊙	↓	↓	⊙	🐶	↓	⚠	↓	2C-T-x
5-MeO-xxT	↑	↑	↑	⚠	⚠	⚠	⚠	⚠	5-MeO-xxT	⚠	↑	↑	🐶	↑	🐶	⚠	🐶	⊙	↓	↓	⊙	🐶	↓	✕	↓	5-MeO-xxT
Cannabis	⚠	⚠	⚠	⚠	⚠	⚠	⚠	⚠	⚠	Cannabis	↑	↑	↑	↑	⚠	↑	⚠	⊙	↑	↑	↑	↑	↓	↑	⊙	Cannabis
Ketamine	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	Ketamine	↑	⊙	↑	⚠	↑	⚠	⊙	✕	✕	✕	✕	⚠	⚠	⊙	Ketamine
MXE	↑	↑	↑	↑	⚠	⚠	↑	⚠	↑	↑	↑	MXE	⊙	↑	⚠	⚠	⚠	⊙	✕	✕	✕	✕	⚠	🐶	⚠	MXE
DXM	↑	↑	↑	↑	🐶	🐶	↑	🐶	🐶	↑	⊙	⊙	DXM	↑	🐶	✕	🐶	⊙	✕	✕	✕	✕	⚠	✕	✕	DXM
Nitrous	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	Nitrous	↑	↑	↑	⊙	⚠	⚠	⚠	⚠	↓	⊙	⊙	Nitrous
Amphetamines	⚠	⚠	⚠	⚠	🐶	🐶	⚠	🐶	🐶	⚠	⚠	⚠	🐶	↑	Amphetamines	↑	⚠	⚠	⚠	⚠	⚠	✕	↓	✕	⊙	Amphetamines
MDMA	↑	↑	↑	↑	⚠	⚠	↑	⚠	⚠	↑	↑	⚠	✕	↑	↑	MDMA	⚠	⚠	⚠	⚠	⊙	✕	↓	✕	↓	MDMA
Cocaine	⚠	⚠	⚠	⚠	🐶	🐶	⚠	🐶	🐶	⚠	⚠	⚠	🐶	↑	⚠	⚠	Cocaine	⚠	🐶	⚠	✕	✕	↓	✕	⊙	Cocaine
Caffeine	⊙	⊙	⊙	⊙	⚠	⚠	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⚠	⚠	⚠	Caffeine	⊙	⊙	⊙	⊙	↓	⊙	⊙	Caffeine
Alcohol	↓	↓	↓	↓	↓	↓	↓	↓	↓	↑	✕	✕	✕	⚠	⚠	⚠	🐶	⊙	Alcohol	✕	✕	✕	✕	🐶	⚠	Alcohol
GHB/GBL	↓	↓	↓	↓	↓	↓	↓	↓	↓	↑	✕	✕	✕	⚠	⚠	⚠	⚠	⊙	✕	GHB/GBL	✕	✕	✕	↑	⊙	GHB/GBL
Opioids	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	⊙	↑	✕	✕	✕	⚠	⚠	⊙	✕	⊙	✕	✕	Opioids	✕	✕	⚠	⊙	Opioids
Tramadol	🐶	🐶	🐶	🐶	🐶	🐶	🐶	🐶	🐶	↑	✕	✕	✕	⚠	✕	✕	✕	⊙	✕	✕	✕	Tramadol	✕	✕	✕	Tramadol
Benzodiazepine	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	⚠	⚠	⚠	↓	↓	↓	↓	↓	✕	✕	✕	✕	Benzodiazepine	↑	⊙	Benzodiazepine
MAOIs	↓	↑	↑	⚠	⚠	⚠	⚠	⚠	✕	↑	⚠	🐶	✕	⊙	✕	✕	✕	⊙	🐶	↑	⚠	✕	↑	MAOIs	✕	MAOIs
SSRIs	↓	↓	↓	↓	↓	↓	↓	↓	↓	⊙	⊙	⚠	✕	⊙	⊙	↓	⊙	⊙	⚠	⊙	⊙	✕	⊙	✕	SSRIs	SSRIs
	LSD	Mushrooms	DMT	Mescaline	DOx	NBOMes	2C-x	2C-T-x	5-MeO-xxT	Cannabis	Ketamine	MXE	DXM	Nitrous	Amphetamines	MDMA	Cocaine	Caffeine	Alcohol	GHB/GBL	Opioids	Tramadol	Benzodiazepine	MAOIs	SSRIs	

SUPPORT US

This information has been researched to the best ability by the TripSit team, and the greatest effort has been made not to include incorrect or misleading information though some information may never be 100% accurate. This chart is meant as a quick reference guide and additional research much always be done. It's not sufficient to only consult this chart when considering a combination. Use at your own risk and please try to be safe. When mixing drugs keep potentiation in mind and start with lower doses of each substance. For more information on specific drugs visit www.drugs.tripsit.me

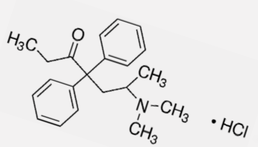
Up-to-date information, details, explanations, and references are published on www.combo.tripsit.me Further information about individual drugs including dosages, durations, and HR advice is available at www.drugs.tripsit.me

MOBILE APP

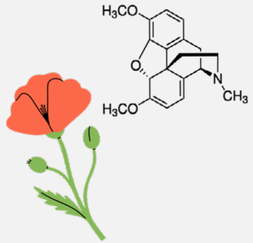
OST MEDICATION GUIDE

OST comes in several forms, but they all work the same way: the OST medication replaces the illicit opioids people are using (heroin or other street opioids) with less harmful, pharmaceutical-grade alternatives, which are prescribed by a medical professional. OST is a controlled medication that needs to be dispensed safely. When starting OST, people consume it under supervision, usually in the pharmacy. When stabilised on a correct dose, clients are often given take-home doses.

Methadone is a fully synthetic opioid because its active ingredients are not found in nature. It is a full agonist, typically in liquid form but also available in tablets, capsules and ampoules. People can also access sugar-free versions of methadone. When a person is prescribed the correct dose (taken once per day), methadone should last at least 24 hours. A long-acting version of methadone also exists, which is taken every three days. Depending on the dose, methadone can give a warm and mildly euphoric feeling but does not offer the full flash effect. While consuming heroin on top of methadone is possible, a therapeutic dose of methadone fills the opioid receptors and reduces the euphoric effect of heroin while increasing the risk of overdose. Mixing methadone with other sedatives and painkillers (e.g., Demerol, morphine and oxycodone) causes respiratory depression (slow and ineffective breathing) and increases the risk of overdose. Methadone is linked to strong retention in treatment and significantly reduces the risk of overdose. It can be given as a short-term treatment to help people stop using opioids altogether, but it is more often used as a long-term maintenance drug. Methadone was developed in 1939 in Germany. In 1949, researchers in Lexington, Kentucky, demonstrated that methadone was the most effective medication for opioid withdrawal, and in 1964, methadone maintenance started as a pilot research programme at The Rockefeller University. Methadone is nowadays available in many countries (e.g., Albania, Hungary, Kosovo, Croatia, Poland, Ukraine and Kyrgyzstan) and is the most commonly prescribed OST medication in the Central and Eastern Europe and Central Asia (CEECA) region.



Buprenorphine is a semi-synthetic opioid derived from thebaine, a naturally occurring alkaloid of the opium poppy. Buprenorphine acts as an opioid agonist (it prevents craving and withdrawal) and a blocker (it prevents other opioids from working). It is usually taken once per day and comes in the form of tablets, which are dissolved under the tongue. However, there is also a form of long-acting depot buprenorphine, which is given by injection once per week or month. Buprenorphine was developed in 1966 in England, and albeit its potential for OST was quickly recognised, it was nearly three decades later that a pharmaceutical company Reckitt manufactured the sublingual form of buprenorphine (under the name Subotex) for OST, which was first released in France in 1995. Buprenorphine is a safe drug that blocks the use of heroin; if using on top of buprenorphine prescription, heroin (or another opioid) doses bounce off and have no effect. Buprenorphine also blocks the effects of other opioid drugs (e.g., Demerol, oxycodone and morphine) and, as such, reduces their analgesic effect. Consequently, buprenorphine is a good drug for detoxing, and it is generally easier to get take-home doses of buprenorphine than other OST medications. Buprenorphine is available in several countries in the CEECA region, for example, Latvia, Georgia, North Macedonia and Romania.



Suboxone is a brand-name medication that contains two ingredients (buprenorphine and naloxone); it also comes in a generic form. It exists in an oral film or tablet form and is dissolved under the tongue. Suboxone has all the main characteristics of buprenorphine with an added effect of naloxone. Naloxone is an opioid antagonist, which means that it entirely blocks the effects of opioids at the receptor sites. As such, it is used for opioid overdose prevention. Suboxone was developed by the pharmaceutical company Reckitt based on the proposal about a buprenorphine–naloxone tablet from the National Institute on Drug Abuse (NIDA); it received approval from the United States Food and Drug Administration (FDA) in 2002. Suboxone was proposed to prevent the risk of abusing buprenorphine, as some people sought to inject the drug instead of taking it sublingually. If a person injects Suboxone, they will immediately experience precipitated withdrawal (dope sickness) due to the blocking effect of naloxone. Suboxone is available in several countries in the CEECA region, for example, Bosnia and Herzegovina, Hungary and Slovenia.

Extended-release morphine

(ERM) is a natural opiate because it is made directly from poppy plants. It is a full agonist taken once per day in the form of capsules. It is generally not prescribed as the first-line OST, but it is useful for people who have tried methadone and buprenorphine treatment without success. ERM provides a stronger warm and pain-blocking feeling than methadone. The usage of street opioid drugs on top of ERM is possible, as ERM does not have a blocker effect, but people often have less incentive to do so. Morphine was first isolated from opium in Germany in 1803, and ERM has been used for OST for several decades; however, it is only available in a few countries, for example, Slovenia, Bulgaria, Austria and the UK.

Diamorphine (pharmaceutical heroin) is a semi-synthetic opioid and full agonist, which is injected 2–3 times per day and administered under supervision. Diamorphine is prescribed only to people who have tried methadone and buprenorphine treatment without success. Diamorphine provides a flash effect, followed by a strong warm and pain-blocking feeling. Diamorphine was first synthesised in 1874 in England, and the prescribing of diamorphine as a heroin dependence treatment was established in the UK medical practice (known as the "British system") by the 1926 Rolleston Committee. Currently, only a few countries (e.g., Switzerland, the Netherlands, Germany, Canada and the UK) provide OST with diamorphine.

Methylphenidate (MPH) is a piperidine derivate; it was first synthesised in 1944 and marketed by Ciba–Geigy Pharmaceutical Company as Ritalin. Initially indicated for various conditions (e.g., chronic fatigue, depressive states, disturbed senile behaviour and psychosis associated with depression), MPH is mainly used for the treatment of ADHD and, to a lesser extent, sleep disorders (e.g., excessive daytime sleepiness and narcolepsy). When used as indicated, this stimulant drug is well tolerated and remarkably safe with a minimal side-effect profile, as demonstrated in disparate patient populations, especially in those with ongoing cocaine use. In line with the stimulant-like effect profile of MPH, common side effects include insomnia, decreased appetite, dry mouth, increased heart rate, headache, nervousness, nausea and dizziness. When potentially more serious side effects occur, they have been found to be reversible with dose reduction or drug discontinuance. Today, various immediate-release (IR) and extended-release (ER) preparations of MPH are available under several brand names in multiple forms for oral and transdermal administration.

METHADONE	BUPRENORPHINE
Fully synthetic opioid. Its active ingredients are created chemically and not found in nature	Semi-synthetic opioid produced in labs from natural opiates
Methadone is a full agonist that can give people a warm and mildly euphoric feeling	Mixed agonist–antagonist that may create feelings of well-being but not a euphoric high
Has more potential for abuse and addiction	The risk of overdose with buprenorphine is very low, as it blocks the use of opioids and also has a ceiling effect, meaning that if people take more than around 30 mg, the effects are not going to increase. As such, buprenorphine is often seen as a safer option and is less tightly controlled than methadone.
There is a risk of overdose if using illicit opioids (including street methadone) on top of methadone prescription	
The withdrawal symptoms when tapering down from methadone are generally more severe	The withdrawal symptoms when tapering down from buprenorphine are generally milder
Better treatment retention and pain control	Has fewer side effects and negative interactions with common medications
It is easier to initiate methadone therapy because people don't have to stop using opioids before starting treatment	Is typically commenced when withdrawal symptoms have begun
Most people stay on methadone for a minimum of 12 months (in some cases, this can extend to 20 years or more)	Buprenorphine treatment duration varies and is often more short-term

Difference between medical and street methadone

Medical methadone is prescribed by a medical professional and includes careful titration (gradual increase) to the right dose for an individual patient, whereas street methadone is sold or given to someone it was not prescribed for. Establishing a therapeutic dose for street methadone is not medically supervised, and the strength of street methadone is never certain, as some people who sell methadone dilute it to make more money. Consequently, street methadone is very dangerous. The risk of overdose and death is particularly high when topping up methadone with other sedating drugs.

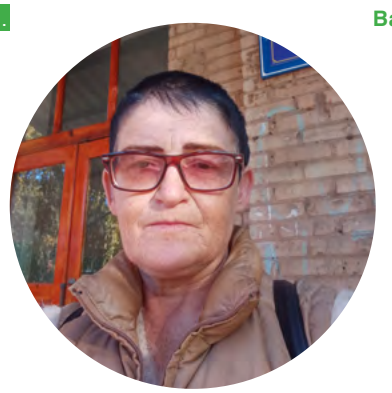
MY LIFE-LONG DAY

Name: Olena,
Country: Ukraine

Expired Passport

The bus stopped at the checkpoint. My heart froze, my stomach shrank... I got up at dawn today. The Donetsk–Sloviansk minibus left at 5 am. I didn't even have breakfast, as I was to receive methadone not in the Donetsk People's Republic (DPR) but in Ukraine today.[1]

I was shaking with fear as I travelled – all I needed was to get to the clinic just to get there on time.



Opioid substitution therapy (OST) site in Donetsk was on its last gasp – it was running out of medication. From that day on, the doses were cut in half for everyone. My 50 mg became 25 mg, and soon, that would be gone as well. The methadone destined for the Donetsk region was lying unused in the Lika Ukraina warehouse in Kyiv, bound to stay there.

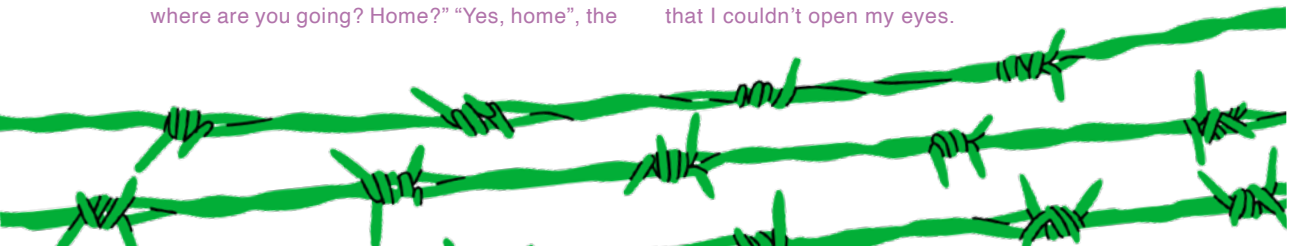
I was on my way to Sloviansk as part of the programme called "Displaced Persons" by the Alliance for Public Health. This small resort town, famous for its salty lakes and medicinal mud, where the turmoil in the Donbas region began, was where my relatives lived. That is why I didn't have the feeling that I was heading nowhere. Although I was still very scared, I was afraid that I would not get through because my passport had expired.

A Ukrainian soldier, a young cheekbone freckled fellow, looked inside the bus: "Citizens, where are you going? Home?" "Yes, home", the passengers answered in discordant unison. The soldier moved down the aisle, quickly checking passports. Following a travelling companion's advice, I put 50 UAH into my passport. As he left, he wished me a happy journey, and the bus started – I'm already in Ukraine! I took a breath. I got through! I will be on the programme!

Back to the future

The whole of 2014 and the first five months of 2015 were terrible with the uncertainty and the constant expectation that I would come in the morning to get the medication and the programme wouldn't work.

I didn't come to OST myself. It was my son who dragged me there – after two years of using "krokodil" (home-made desomorphine), I had fallen very ill. My legs, destroyed first by intravenous and then intramuscular injections of desomorphine, did not want to hold me. While my son arranged a place in the programme for me and the necessary papers were being prepared, I was lying at home, suffering from several simultaneously ripening abscesses and panicking that I simply would not live to see the programme. Although there was plenty of "krokodil", there was nowhere left to inject it. And on the second day of withdrawal, I began to develop acute renal failure; I was so swollen that I couldn't open my eyes.



I remember the first time I received methadone. It was a real treat. That's it; I don't have to inject that unthinkably painful and poisonous "krokodil" anymore! I am going to live!

However, I had to stay in the ward for a very long time because I could barely crawl: first on crutches, then using the wall. How would I manage to take two means of transport to get to Budyonovka every morning? After breakfast in the ward, I would slowly crawl down from the third floor with a bottle of water in my hand, waddle to another building where there was an OST unit, take my medication, then crawl back, wait for my son to bring me a food parcel, and then sleep, sleep, sleep...

When it got easier, I moved home. And then, as my new OST patient friends said, I "drifted back", or, in other words, came to my senses: I got a haircut and dyed my hair. Soon, the abscesses healed, and my elephant legs began to return to normal. I felt incredibly free. And when old acquaintances came over to prepare "krokodil", I just didn't open the door. I had new interests and new friends. I was happy. But then the war started, which took that happiness and freedom away from me.

That very woman from Donetsk

And so, I got out of Donetsk and felt free and happy again – I was on my way through Sloviansk to the drug treatment centre. This treatment facility amazed me. After the shabby walls of the OST clinic in Donetsk, the gloomy corridor and the cracked floor, it was clean and freshly painted, with lace curtains. Carrying a bag with all my belongings, I walked through the clinic in search of the doctor.

A big old woman with an angry face and crinkly lips was sitting in the office. Instead of "hello", she asked me, "What? Did you come to gobble up someone else's pills?" Then, she looked at her watch and informed me that I had arrived too late and would not get the medicine today. I objected, "Well, it's only twenty past nine, and the site runs until half past ten!" Then, the doctor looked at me as if I were a little bug who suddenly burst out with a voice. "I still have to examine you and do your paperwork." I'm ashamed to say that, but I started to cry and beg her. "All right", said the doctor condescendingly. "Give me your papers..."

Read the rest of the story on the EHRA website

Olena Kurlat, Ukraine

[1] In 2014, Russian military forces occupied part of the Donetsk and Luhansk regions of Ukraine. In the occupied part of the Donetsk region, the so-called Donetsk People's Republic (DPR) was formed. Due to the fact that OST is prohibited by law on the territory of the Russian Federation, the same rules were adopted on the territory of the occupied Crimea, DPR and Luhansk People's Republic (LPR), closing the OST programmes, as well as condemning those patients who receive the treatment on Ukrainian territory for drug smuggling (Free Natasha Zelenina https://www.facebook.com/FreeNatashaZelenina).

A LITTLE SUNSHINE IN THE COLD WATER

Name: IRINA,
Country: KAZAKHSTAN

So, let's get acquainted. My name is Irina, I am 38 years old and I have been living with my boyfriend in a civil partnership for over nineteen years. We haven't had any children during our life together because most of it has been spent on heavy drugs and on "business trips" to detention facilities. This was also the reason why we ended up in the opioid substitution therapy (OST) programme, as we wanted to be done with our dependence.

I now realise that the programme is primarily about reducing the frequency of injecting various opiates and not about getting rid of them altogether. When I joined the programme, I initially hoped to raise my dosage in six months, then lower it and then get out of the programme safely, but it took me a while. Despite all the difficulties, my partner and I live together in a small cosy flat not far from the OST site. I would also like to say that I am from Ust-Kamenogorsk, which is in the east of Kazakhstan.

In my spare time, I draw, read books and go jogging in the evenings. I love nature, walking outdoors, ice skating and hiking in the mountains. I could tell you many more things that I love, but life is very limited. For instance, because of the substitution therapy programme, we have no opportunity to go on a trip to the countryside with our parents or with a group of friends for a couple of days because we are not given any take-home medication. It is a shame to say, but I haven't been to the seaside for fifteen years. This situation is one of the problem spots in the programme.

Should such a trip occur, if all initially goes well, by the evening of the first day, my well-being will begin to deteriorate due to the impending withdrawal syndrome, and it will then only get worse and worse. It will not just be a bad holiday; it will be totally ruined, not only for me but also for those around me. I will be nervous, rude; my loved ones will feel sorry for me and give unnecessary advice, especially if it's my mother or friends who do not understand the intricacies of my well-being. Therefore, for the time being, my only recreation is a beach on the bank of the Irtysh River, where the water is very cold, or the muddy Ulba, covered with litter along the entire bank.

The journey from point A to point B

My daily journey from home to the site takes from fifteen to twenty minutes on foot through courtyards, past shops, kindergartens, schools and the library. The pharmacy is the most interesting location on my route. Coincidentally, it is one of those pharmacies that dispense illicit drugs without a prescription (tramadol, Somnol, dimedrol, tropicamide). You'll almost always find interesting faces here, including police officers looking for the next victim. Nearly every day, there are some curious incidents here. By the way, some of our patients are quite frequent visitors to this place. I don't judge them because I was one of them myself for a while.

Next, I walk over the pedestrian crossing, and the red light has been on for almost two minutes. I wait for the green light and look at the zebra: a black stripe, a white stripe – just like in our lives. Today things are bad, but tomorrow, they will change for the better. It rains in the morning, and it is sunny in the evening. Everything in the world is ever-changing. But in our life, nothing changes. Laws are changing, officials are changing, medicine is advancing, new technologies are emerging, e-learning is on the rise, etc. During the pandemic, many areas of life, in general, have become distance-based: food delivery, online shopping, online platforms for various events. The whole world has started to live by new rules. But we cannot change anything in our little world of substitution treatment programme because the people who set these rules do not want to hear us and do not want to know about our problems.

In the very first lockdown, most developed countries adopted measures in their opioid substitution therapy programmes allowing at least five days of take-home doses. We were not among those countries. In Kazakhstan, the substitution therapy programme has been a pilot project for eleven years. Just as we would go every single day to the narcological dispensary for a daily dose, we still do. Be it a pandemic, extreme heat, frost or no transportation service – no big deal, we manage to find a way in any hopeless situation.

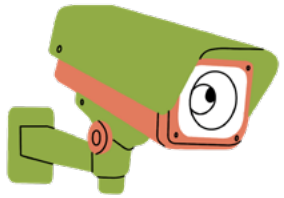
After all, we have been through fire and water, especially during the time when we were in an irregular situation. Why feel sorry for us? Even after surgery, we would still come the next day on crutches and climb up to the fourth floor for a glass of this "life-giving water". I remember a case like this: I've taken my "dose", and going down the stairs, I find one of our patients, who has just had a kidney removed, climbing up to the fourth floor. He walks up, quite briskly, with a tube sticking out of his side, from which some liquid is dripping into a glass jar he carries in his hand. Yeah, that's how we live.

A building with bars on the windows

The building of our narcology department is in the middle of a residential area, almost in the city centre. You can get there by bus from anywhere in the city. However, the problem is that buses are running late, and they are usually overcrowded. And

now it's still hot, up to forty degrees, it's summer, and again the pandemic isn't over and wearing masks in public places is obligatory. The premises of the narcology clinic are a dull five-storey building with barred windows from the ground floor to the third floor. The building has two entrances. The first entrance is the narcology department, and the second one is the psycho-neurological department for children.

And now, let's have a little tour to see what's inside the first entrance. The ground floor houses the regional AIDS centre, where five other patients from our site and I work as outreach workers. By the way, it is very convenient, but unfortunately, not all folks are so lucky with their jobs. So, I combine, as they say, business with pleasure. Sometimes I have to consult people looking for the AIDS centre, accompany them and provide them with psychosocial support. Further up, on the first floor, there is a children's psycho-neurological ward. On the second floor, there is an in-patient unit for people with alcohol dependence. On the third floor, you find the administration and registration office of the regional narcology clinic. Finally, on the fourth floor, there is a polyclinic and a methadone dispensary, as well as an in-patient unit for people with substance dependence.



Coming to the dispensary I go up to the fifth floor every day, to the right along the corridor, the second door on the left is the methadone dispensing office. The room has a two-by-two-meter barred window. The other part of the room where the nurse is located is fenced off with bars too. Through this bars that they give us methadone. There is a CCTV camera in the patient room, and the monitor is in the part where the nurse is sitting.

In the nurse's room there is a safe, a refrigerator with water, two tables. On one of the tables are our cards with names and appointments.

Another counter is the one where they pour methadone for us. There is a bottle of methadone syrup and a porcelain bowl into which the syrup is poured. From this bowl, they take out our dosage with a 10-cc syringe and pour it into plastic cups, top it up with plain water from the bottle and then give it to us. We take our dosage and have an extra cup of water. On the windowsill, there is a water bottle and some plastic straws for cocktails. There's this alternative: you can drink it through a straw or chug it down if you like. There are also some announcements and a dispensing schedule in our part of the unit. In terms of the schedule, methadone is dispensed between Monday and Friday from 7.30 am to 9.30 am. There is a break from 8 am to 8.30 am so that the nurse can fill out patient cards and use the bathroom.

At weekends and on public holidays, methadone is dispensed from 8 am to 10 am. Sometimes, if the nurse is late or opens at 7.30 am sharp, there is patient outrage about this. The folks shout to the nurse: "You're late, we're late for work too, it's hard enough for us to get a job anywhere." But the site usually opens at 7.20 am. This working schedule is another problem, although not the most important one…

Read the rest of the story on the EHRA website

Irina Selina, Kazakhstan

OST ROUTINE OR AMORTISATION OF DEPENDENCY

Name: Kestutis,
Country: Lithuania

My day-to-day life is now filled with happiness – after a three-year break, I got the benefit: I can now pick up my medication once a week. It's awesome and gives me a different perspective, so to say. This way, a trip to the clinic on Monday is an important event of the week – like a holiday – rather than a daily routine with an unpleasant undertone or aftertaste. This negativity is usually created by having to travel every day to get your potion, which is very tiring. It creates different tinges that make you feel bitter inside, and the world turns grey in your eyes. After all, you have to go there in any weather – either on foot (the "feeder" is not in the centre) or by public transport, with or without a ticket, but you have to go anyway because you don't want to be clucking.

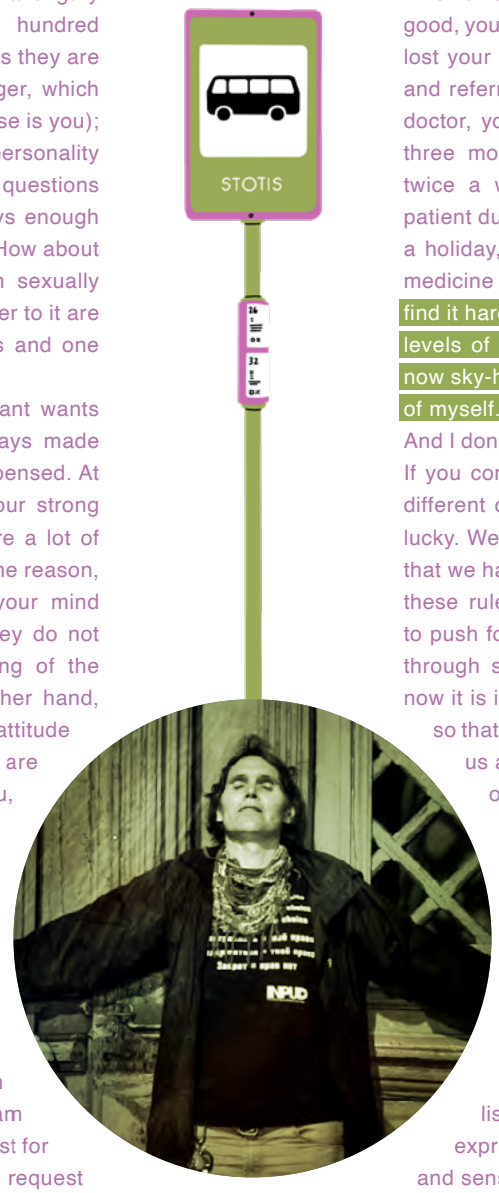
But most people put up with it. After all, it's easier to put up with it, and we're used to it.

Getting the privilege to receive OST once a week takes stamina and determination. It's not an easy challenge when you feel rattled and have internal conflicts, anti-social phobias and other kinds of unpleasant internal conditions. First of all, being an OST patient, you have to have social insurance, and in order to get it, you either have to work, or be on the unemployment register, or have a disability, or well... pay forty euros a month for your social insurance to the state. The paradox is that if the insurance provider does not get this money for you every month, you cannot get any health services, but the forty-euro monthly debt still drips off. A funny kind of social justice, which is called obligatory social insurance here.

The next step is that you have to fill in a lengthy questionnaire with more than a hundred questions for your social worker, or as they are now fashionably called, case manager, which means "case consultant" (and the case is you); this questionnaire uncovers your personality to the very last boundary. Not all questions are pleasant, and there is not always enough privacy to fill out this questionnaire. How about this question: Have you ever been sexually abused? This question and the answer to it are heard by three other social workers and one patient.

Additionally, whenever your consultant wants to see you, an appointment is always made for a visit before the medicine is dispensed. At this meeting, on the occasion of your strong desire to get the medicine, there are a lot of questions waiting for you, but for some reason, I have never been told: "Go get your mind right first and then come back." They do not show any empathy or understanding of the patient's condition at all. On the other hand, some younger staff have a positive attitude and learn from experience. There are occasions when they listen to you, so there is hope that they can show more humane and accepting attitudes over time.

Then, you have to get a referral for OST from your family doctor. Then, you have to go to the TB centre, and after an X-ray, the doctor gives you a certificate that you do not have tuberculosis. On even-numbered days between 7 am and 9 am, you have to take a blood test for HIV and hepatitis. Then, at the first request and without any chance to refuse, you have to take a urine test for a variety of substances: eight psychoactive substances, all of which must be negative. And only then, if the doctor agrees, you get your first seal of approval. For three months, you are allowed to pick up your medication every other day. Sometimes you even think it would be easier to learn tap dancing. But it's not in the protocol.



If for three months your tests have been all good, you have been polite to the staff, have not lost your insurance, have the right certificates and referrals, then, with the permission of the doctor, you can move onto the next level: for three months, you can collect the medicine twice a week. If you prove to be a model patient during this time, then Monday becomes a holiday, and you are allowed to go for your medicine once a week. Let's be honest; I still find it hard to believe that I have passed all the levels of these challenges. My self-esteem is now sky-high. I can say even more: I am proud of myself.

And I don't hold a grudge for those three years. If you compare our programme with others in different countries, you could say that we are lucky. We all have the kind of OST programme that we have fought for ourselves. And even all these rules. At some point, it was necessary to push forward positive changes step by step through solidarity and patient advocacy. And now it is important to continue to do the same, so that the OST programme is convenient for us and helps us, rather than complicates our already difficult lives as people who use drugs. But because the substance dependence centre is a big and clumsy ship with its own rules and requirements from the top of the various ministries, sometimes certain changes get so crooked and askew.

We are also fortunate to have senior staff who, no matter what, often listen to us, especially if requests are expressed and presented in a timely, clear and sensible manner. As practice has shown, unfortunately, not all patients who receive OST are able to withstand the challenges of the system, such as having social insurance and obtaining various and often unnecessary certificates and referrals. And not all of them have the will to answer a hundred unpleasant questions and also stop using additional street drugs or different variants of the supplements, from beer to dimedrol and clonazepam.

But because methadone has this important property of amortising all other substance use, it becomes less frequent. A desperate person is not going to commit crimes; they will do everything it takes to get better and are generally not ready to give up stability so easily. I'm glad that those responsible for the quality of the OST programme understand this, and for passengers like me, i.e., patients, they made a mobile clinic to dispense the medication. The therapy minibus is parked in remote locations away from residential areas, and the drug is administered there for three hours every day.

Yes, we are not being thrown out of the programme with a high dose on the street, which would mean sure death to body and soul. However, it is absurd that the mobile clinic is not working either because of lack of funding or because of the quarantine, and all OST patients have to go to one site. This site is open from 7 am until 6 pm, and all benefit requests are processed there, and tests and questionnaires are administered. The other site, the mobile unit, which is right in the centre of social work, has a dispensing time of only three hours, from 9 am to 12 pm in the morning. If you get there a couple of minutes late, you're out. It is probably done this way so that "unstable" patients don't get used to good and human treatment.

I was pleased that the last time I spoke to the chief physician, I felt that he understood us. We talked about how other drugs such as diacetylmorphine (pharmaceutical heroin) or long-acting buprenorphine could be included in the substitution programme. Scandinavia already has it: you take it once every three months, and you can live your life in peace, and only as an antidepressant, you get weed of all sorts and sizes or CBD medication. So far, it sounds like a dream, but as they say, one must have a dream and believe in something; otherwise, it is death. So, I wish for you to have your dream!

A long-time OST patient who has lost track of time.

Kestutis Butkus, Lithuania

Read more stories from Natalia and Marina from Belarus, and Victor from Ukraine on EHRA website

OST ROUTINE OR AMORTISATION OF DEPENDENCY

CHECK IT OUT!

enpud.net
harmreductioneurasia.org