

CROATIA

A Look at the History of Opiate Addiction Treatment

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Croatia, one of the youngest European states, but one of the oldest European countries, has been waiting for more than nine centuries to reconstitute its independence. Unfortunately, waking up after a long dream was not pleasant at all. As it typically happens in history, the war was the price for freedom. The war between 1991-1995, brought not only victims, destruction, and migrations, but also a heroin addiction epidemic. Croatia is situated on the famous "Balkans Route" of heroin supply for west Europe, but till the early 1990s heroin addiction was sporadic or local, but not a national problem.

Whereas for most challenges the government found some kind of answer, there was no answer for the heroin epidemic. The supply reduction was undermined by the war crisis and war related crimes, but at least it was clear what should be done. The demand reduction, however, was something no one knew how to handle. Methadone was offered as an option, but for the government it was extremely controversial and under suspicion from the "moral authorities".

Holding a "hot potato" and not knowing what to do, the government chose to do nothing. They left the problem to the medical specialists and experts, without any declarative act or regulation! Fortunately, that was the best solution for Croatia .

Introduction of methadone in treatment of addicts, 1991

In Croatia, methadone for treatment of addicts was introduced through a "slightly open door". As an opioid analgesic for severe, mostly cancer pain, it was widely prescribed for more than 30 years, but the idea of using opioids as a medicine for opioid addiction, seemed unimaginable. Methadone was frequently misused by heroin users as a "substitution", so "how can medicine which is misused and persecuted be a therapy against addiction"? Since heroin addiction was not a substantial public health problem, it was not necessary to think about it ". But the problem grew and the need for new treatment options became imperative. The first to understand the situation and the new importance of methadone was Dr. Sakoman, head of the Department for drug abuse at "Sestre Milosrdnice" University Hospital in Zagreb. Founded in 1970, this department was the first of its kind in former Yugoslavia. He used methadone first for inpatient detox. But inpatient use was never "questionable", unlike outpatient treatment! In 1991, the first inpatients were released and referred back to their own doctors to finish methadone detoxification. It was a success without exception! The door was open and methadone was on the scene!

How was it possible for such a controversial therapy to continue without an official act of enforcement? Without considering the sociological setting, that is probably important, some of these factors might be part of the answer:

Since there was no official introduction of methadone, it could? not be debated within a public, political or medical community and thus there was no significant opposition.

GPs, who took on the greatest part of? Methadone Treatment, in early 1990s were still on a state salary and accepted practically all recommendations coming from hospitals within the health system.

Methadone entered through detox programmes and was seen as? "temporary therapy". Substitution and maintenance were not the terms used in the beginning.

The personal influence of Dr. Sakoman on introducing? methadone and promoting humanistic, public health approach for heroin addicts is not measurable.

But above all other factors: addiction was treated as a medical problem. That made treatment possible. A philosophy of "addiction as any other disease" and "methadone as any other medicine".

Thus like any other disease, no written programme with strict rules, just the principles that are unchanged till now:

Methadone should be offered and provided to anyone? who needs it.

No selection criteria for entering the programme (Age,? period of addiction, history of failed treatment attempts, should be considered as factors of inclusion) nor were there exclusion criteria (age under 18 -generally not recommended for MT, but in a certain condition possible).

Practically no discharge policy. Illegal opioid consumption? is not a reason for discharge. Discharge can happen as an "individual event" and not as a consequence of the policy.

Implementation phase: 1991-1996

Once started, Methadone Treatment in a short time changed dramatically the treatment of addicts. Discussions and arguments started, but nobody could "push the genies back in the bottle". In a couple of months the first hundred addicts entered the programme, through the end of 1995, more than 1500 were treated. There were no significant problems in prescribing and dispensing methadone, but it became evident that a centralized methadone induction was insufficient and needed to be changed. Finally, in 1996 the Croatian parliament accepted the "National strategy for drug abuse control", the first document about drug prevention, treatment and illegal drug supply reduction. "Strategy", however, was not law and did not obligate anyone. It was the first document indicating government support for the programmes that existed already for more than 5 years!

The "Strategy" practically described the programme already in place and emphasized the known principles of treatment. The crucial news was the suggestion of establishing "Centers for outpatient treatment" in all counties and bigger towns, with the aim to alleviate specialty care and enhance availability of treatment.

Establishing phase: 1996-2001

After 1996, Centres for outpatient treatment were established in all the areas facing drug problems, 15 so far. Again, there was no central administration enforcing this important step, but local communities, which took the initiative and provided funding. But the Centres showed the need for a legal framework to handle the drug problem. Five years after the "Strategy", in December 2001, there are endless political confrontations and numerous compromises and insufficient solutions.

Actual situation and comments

Today, Methadone treatment in Croatia is well established and despite all the inconveniences, is generally well accepted.

The three cornerstones of the programme are:

1. Network of Centres for outpatient treatment

Centers are the focal points for outpatient treatment. According to a clinical assessment they may include methadone, decide starting dose, type of treatment, regimen, suggest supplementary medication, provide psychosocial counseling, do evaluation and collect epidemiological data. Centres have employed interdisciplinary team (medical practitioner, psychologist, social worker, medical nurse). Psychiatrists are typically in charge of the Centre, but other specialists or general practitioners with supplemental, mostly informal education can be as well.

Non-psychiatrists seem to do their work as successfully as psychiatrists and are well accepted by patients and colleagues. Apart from the fundamental principles already addressed, there are other factors influencing the efficacy of Centres:

Good availability – the Centres are situated in all cities? facing addiction problems, usually in a convenient location.

There are? no waiting lists for entering.

All services, including psychosocial? counseling are free of charge.

2. General practitioners prescribe and dispense methadone

In Croatia, methadone centres don't exist. Methadone Treatment is consequently decentralized thanks to GPs, who took on the hard work in MT. The philosophy of methadone "like any other medicine" can exist only "on the shoulders" of GPs. An addict after an assessment in Center is referred to his own doctor, and his doctor continues prescribing methadone and not only prescribing, but also dispensing!

A doctor or a nurse has to get methadone from the pharmacy and provide it for consumption, usually daily supervised consumption in the office. Moreover, for take home doses a nurse has to prepare a solution, since there is no methadone syrup in Croatia: to crush methadone tablets and mix it with juice (that usually have to be procured by doctor!) A Dense and well-developed network of GP offices makes methadone available in "every village". It is estimated that out of 2400 GPs in Croatia more than 1000 have patients on MT. A great majority of doctors accept the MT situation and disagreement is rare, despite all the problems they meet.

3. Good health insurance coverage

While Center services are funded and thus completely free of charge, methadone dispensing is available for virtually all addicts having access to health insurance. If not insured, which most of them are, an addict gets full insurance because of his addiction. That fact has an enormous influence on access and on retention in the programme.

Problems and obstacles

Methadone Treatment has become an inextricable achievement of the Croatian health and social system. Although obstacles thus far have been insignificant, some are growing and threatening the principles of the programme.

Traditional drug free? orientation. Although MT is highly available and free of limitation or restriction, there is still a strong drug free orientation. There is permanent claim for "less methadone" not only from providers, but also from families and even addicts themselves! Addicts don't "like" the term maintenance and prefer the expression "very long detoxification"! That fact influences many outcomes of MMT.

Lack of the methadone rules became a problem. Although for? introduction of methadone, rules missing played a "historical" role, there is growing need, not for rigid regulation, but simply for a described procedure and guidelines. Lack of guidelines is one of the reasons for diversion and errors. Misuse later appears in the media and acts to undermine the programme.

? Paying of GPs participating in programme. Health authorities don't accept the idea of paying additional funds to GPs, for the hard work in prescribing and administering methadone, given it is "just another disease". For example, GPs are paid by capitation which is 134 kunas per year (cca17 Euro) per person, that includes complete primary health service and, in case of an addict, every day supervised intake of methadone! In 2001, the Minister of Health rejected a proposition of an additional 25 Euro annually for all GPs in Croatia having patients on MMT!

Claim for centralization has its advocates. Only? argument for centralization is

dispensing and consequently "elevation of threshold" is methadone diversion! Behind these ideas stands interest of establishing MT structure and the bureaucracy under politician's control.

Facts and indicators

Basic information on Croatia:

Population: 4,500,000
Estimated heroin addicts: 15,000
Heroin addicts in treatment: 7,000
On methadone treatment: 3,000
In Methadone maintenance: 2,000

Of 4000 registered addicts not on methadone, about 800 are in therapeutic communities, 500 in prison, more than 1000 are in "drug free programmes" that means good contact with Centres, good social function, mostly employed or studying and abstinence or rare opioid consumption.

HIV infection and AIDS - Croatia has a low overall HIV infection rate. Estimated at 0.0015%. There has been only 171 AIDS cases since the beginning of the epidemic through 2000. HIV infection rates of heroin addicts is 0.8 –0.9%. It is difficult to say that such good results are not partly due to the availability of methadone!

Hepatitis rate - About 50% of addicts are HBV or HCV positive.

Average dose in MMT is estimated at 65 mg.

Overdose deaths in the last couple of years are between 50-60 annually.

Diversion of methadone - It is hard to estimate the proportion of methadone being diverted, but the price of methadone on a "black market", which is 10 times bigger than in pharmacy suggests that it is not substantial: 30 Euro for 100 mg. dose on the street and 3 Euro in the pharmacy. Not more than 10% of overdose deaths attributed to methadone, support such estimate.

Retention rate is estimated to be over 80%. Of 119 addicts in treatment in Center in Porec, 99 (83%), are still in the programme.

Conclusion: Despite a lack of strict rules or just because of that, methadone treatment in Croatia is well established and generally well accepted. The obstacles so far have not been significant and never reached a height to jeopardize the fundamentals of the programme. The concern of diversion seems to be exaggerated and a claim for better control and centralization just another name for a "high threshold" programme, poor availability and politicizing of a "normal" public health problem.

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