THE TREATMENT OF HEROIN ADDICTION: SOME LESSONS FROM ABROAD

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When a society like ours allows the drug industry to promote its wares to the extent that has occurred in this State, the victims of that trade are entitled *as of right* to the best available treatment. While the nature of that treatment remains a matter of clinical judgement, two things should be clear to anyone willing to learn from international experience. The first is that the scale of the treatment program needs to match the epidemic that is upon us. The second is that methadone must necessarily be a significant part of any worthwhile program to treat heroin addiction.

I intend to illustrate the second of these lessons with some recent observations of treatment being offered in Sweden and Holland. I would like to preface my remarks with a general comment on the legal response to the drug industry. A number of European countries whose mild and considered handling of crime I admire, are taking stern action against those who profit from the drug trade. The same countries are making enormous efforts to meet the needs and rights of the drug dependent. For example, Holland, a country in which a prison sentence of more than a few months is considered something of a tragedy, is handing out sentences of upwards of fifteen years to the principals of the drug trade.

THE NETHERLANDS

Heroin addiction is no less difficult to quantify in Holland than elsewhere. By the criterion of sustained use for two years or more, the population of heroin addicts is estimated to be of the order of 20-25,000, perhaps around a third of the rate in New South Wales. Approximately one in four receive methadone treatment in one of its various forms. Unlike Sweden, control studies of the usefulness of methadone treatment that fulfill the highest scientific standards, have not been undertaken in the Netherlands.

Therefore it has been necessary to try and learn whatever is possible from practical experience. Unlike Sweden and Australia where governments have used administrative means to limit the availability of methadone treatment, the authorities in Holland have been trusted to use their professional judgement and good sense in developing a methadone program.

Because the program has been developed in a responsible way, there has been little political interference or even debate about the use of methadone.

What practical lesson have the Dutch legal authorities learned about the use of methadone? The first broad lesson concerns the impact of treatment on the life situation of heroin addicts. Previously many of them had deteriorated socially and physically to the point where they were a distinguishable lower level in society — "living in the gutter" to quote a leading government consultant. Heroin addicts receiving methadone treatment have now merged with the general offender population so far as health, social appearance and general functioning are concerned. To quote the same consultant, "The level to which addicts can descend has been moved upwards".

Another general benefit has been that methadone treatment has necessarily placed a large number of addicts in regular contact with treatment and social support staff. It has been found that the advantage of this arrangement is not that such staff can directly influence addicts to become independent of heroin or methadone, but that when the addicts themselves are motivated to lessen or discontinue their dependence, informed support is readily available.

The next lesson concerns an effect of methadone treatment that is something of a mixed blessing. Many addicts who no longer have to maintain a constant schedule of stealing in order to finance their habit, still continue to engage in theft but on a more considered, planned basis. Of course, it makes no sense to attribute the continuation of such criminal activity to methadone treatment but from the police point of view it has helped to transform some impulsive, inept and readily detected thieves into more skilful operators.

When it comes to assessing the types of treatment that have proved most beneficial, allowance must be made for differences of attitude among medical officers. For example, some doctors within the Dutch prison medical service are opposed to the use of methadone. The ambivalent attitude of others probably affects the response of addicts to the services provided. However, in the experience of the Ministry of Justice, when prisoners are extended the patient's right to participate in the choice of treatment, they mainly opt for one of two things. They either ask for detoxification based on methadone reduction or some other form of treatment requiring no medications or tranquillisers.

A small but increasing number seek (and are given) methadone maintenance.

A study of requests for treatment by heroin dependent inmates at two reception prisons in Haarlem between 1979 and 1983, showed that the preference for methadone detoxification remained fairly constant. It was requested by around half to two-fifths of those seeking help each year. Only in 1982 and 1983 was methadone maintenance requested by as many as 12-15% of those asking for help.

The fact that requests for methadone maintenance have not exceeded this level is important for societies that are apprehensive about providing such treatment in prisons. Fears that requests for methadone are likely to get out of hand and other forms of assistance ignored, are not borne out by the Dutch experience.

Moderate to low levels of dosage are used in the prison methadone maintenance program. It is not altogether clear how heavily addicted inmates adapt to the regime or the extent to which they supplement methadone with heroin brought into the institutions. The medical staff are aware, as are senior staff in the prisons that I visited, that there is trafficking in heroin. So far as community treatment programs are concerned, the Dutch authorities attempt to limit the number of clients of any single treatment unit to forty. Groups of that size permit the degree of surveillance needed to detect the intrusion of traffickers anxious to exploit the marketing possibilities represented by the treatment group — the so-called 'honey-pot' effect.

SWEDEN

By comparison with New South Wales, Sweden has only a small number of heroin users who have taken the drug consistently for two years or more. As always, it is difficult to make a precise estimate of the number of people affected. Nevertheless, from discussion with Professor Lars Gunne, probably the country's leading researcher in the field and the Head of Sweden's main methadone treatment centre in Uppsala, we can put the figure at around 1500. This would mean that, conservatively estimated the New South Wales rate is around twenty times higher than that of Sweden.

The centre that Professor Gunne directs in the Ulleraker Hospital has about twenty in-patients. They receive psychiatric, psychological, and social work services and also benefit from the presence of other scientific staff. For a number of years the extension of methadone treatment has been resisted by a number of community groups. It has been restricted to only a fraction of those who Professor Gunne believes could benefit from methadone maintenance.

That situation has now changed dramatically. During my visit earlier this year I met the recently appointed Director of a new methadone treatment centre in Stockholm and the Uppsala team received government permission to increase the scale of their program. The main reason for this change has been the result of research carried out into the effectiveness of methadone treatment. It is not often that one comes across evaluation research that has been as carefully executed as the work undertaken at Uppsala, but before outlining the findings of this research I need to comment on two things. First, I should make it clear that much more than methadone is offered to those being treated at the Ulleraker Hospital. Second, I need to tell you something about the criteria for admission to the program.

The prescribing of methadone is regarded by staff and patients alike as only the first step that enables other constructive things to be done in an addict's life. Group discussion, personal and vocational counselling, group visits to possible places of employment, joint recreation and outings, are all essential parts of the regime. The criteria for admission to the program include:

(i) a minimum of four years' history of compulsive misuse of opiates;
(ii) withdrawal signs and urinary opioid excretion measurable on admission to the clinic;
(iii) a minimum of three earlier completed detoxifications;
(iv) attainment of at least twenty years of age; and
(v) no dominating abuse of non-opiate drugs.

An evaluation of the total methadone maintenance program comprising 170 individuals, has shown favourable effects on drug abuse, vocational rehabilitation and delinquency. However, the most compelling evidence has come from a carefully controlled study in which matched male patients were distributed by random assignment to either a methadone maintenance or drug-free treatment group. Progress of the patients was assessed in terms of illicit drug use, criminal activity, work adjustment (including formal participation in study), health, and significantly, survival.

Time does not permit the year by year comparison of the fate of the two groups of 17 patients. After two years, twelve of the seventeen within the methadone treatment group were free of drug abuse and had started work or studies. Five within this group continued to use drugs (opiates or hypnotics). On the other hand, only **one** of the seventeen in the non-methadone treatment group had abandoned his drug habit (see Figure 1).

Perhaps the best way of summing up the findings of the research is to report the progress achieved after the passage of an average treatment period of around four and a half years. Thirteen of the methadone group had ceased to abuse drugs and had obtained regular jobs. Four had to be classed as therapeutic failures and had left the program. For the non-methadone group the outcome was very poor, only one out of seventeen patients having become drug free (six per cent), whereas in the methadone treatment group seventy-six per cent were considered to have been 'rehabilitated'. The non-methadone patients either died, acquired serious infectious diseases, or ended up in prison. The annual death rate for these drug abusers (twenty to twenty-four year olds) was 59 times the expected rate for their age group in Sweden. Actually the death rate in the

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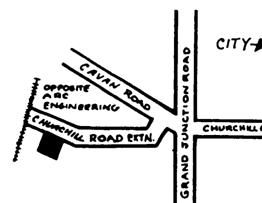
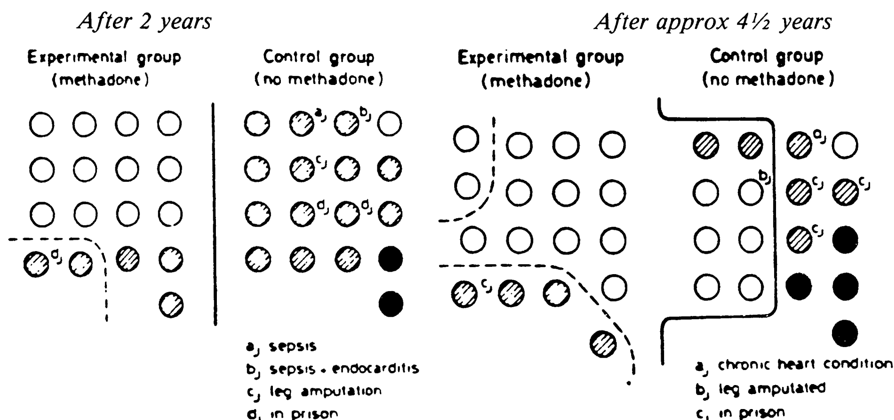


FIGURE I: RESULTS FROM EXPERIMENTAL GROUP (METHADONE) AND CONTROL GROUP (NO METHADONE). Gunne and Gronbladh (1981)



Cases within the experimental group which have been expelled because of abuse of hypnotics are shown behind the broken lines. White circles = no drug abuse; hatched circles = on-going daily abuse; black circles = deceased.

non-methadone group (four out of seventeen) has to be regarded as a minimum figure, since about half of this group at a later stage applied to be admitted to the methadone program and were given this opportunity (Figure 1).

At this point, let me note a striking similarity in the findings of research conducted virtually at opposite ends of the earth. In 1981 Professor Gunne wrote that the Uppsala findings "support the view that methadone maintenance treatment protects against drug related disease and death in heroin addiction". Writing around the same time two Australian workers (Dalton and Duncan, 1980) concluded from a follow-up study: "We thus realised that methadone was keeping patients alive".

Lest it be thought that the findings of Gunne and his co-workers are based on small numbers I should add that the findings for 170 patients, including 39 women, closely resemble those of the above study. The percentages of those free of drug abuse and still in treatment and those who have voluntarily left the program and remained drug free, are very similar.

Finally, Professor Gunne believes that the success of the Ulleraker program partly reflects its small size and controlled operation:

> It is a paradoxial observation that small operations receiving only very severe cases often have an easily demonstrable beneficial effect, whereas attempts to allow also milder cases . . . tends to lower the efficacy down to a point where it becomes impossible to demonstrate any superiority of MMT over drug-free treatment or even no treatment. Our Swedish program is an example of a small operation which has managed to retain not only the original admission criteria but also the favourable results of the early American MMT programs (Gunne, 1983).

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