

Methadone Treatment in Croatia

Ante Ivancic

Summary

The war between 1991 and 1995, brought destruction, migrations and victims to Croatia, but it also brought a heroin addiction epidemic. The supply of methadone was undermined by war-related crimes and demand was paralysed by confusion about the options that were available. Croatia did have a number of experienced specialists in the field of addiction, and, fortunately, their ideas were accepted and promoted. Methadone was introduced through a "slightly open door", but no official announcements were made. The first patients were admitted to MT in 1991. Of an estimated 15,000 heroin addicts, about 7,000 were given some kind of treatment, including 3,000 in MT, and about 2,000 in MMT. Methadone policy specifics are: 1. Health insurance coverage that includes MT for virtually all addicts. 2. Centres for outpatient treatment in all major cities. 3. Completely decentralized prescription and dispensing of methadone through GP offices. Despite the lack of strict rules, or maybe just because of that, MT in Croatia is well established and is generally viewed favourably. The obstacles encountered so far have never reached a level that might jeopardize the fundamentals of the programme.

Key words: Methadone Treatment - Problems and obstacles -
Policy Initiatives

Croatia is one of the youngest European states, but one of the oldest European countries; it had to wait over nine centuries to win back the independence.

Regrettably, reawakening after a long dream was not at all pleasant. As typically happens in history, war was the price for freedom. In this case war lasted from 1991 to 1995, bringing not only destruction, migrations and victims, but also a heroin addiction epidemic. Croatia lies on the famous "Balkans Route" of heroin supply for west Europe, but until the early 1990s heroin addiction was sporadic or local, rather than a national problem.

The government found some kind of answer for most of the challenges it faced, but it had no answer for a heroin epidemic. The supply of methadone was undermined by

Address for reprints: Ante Ivancic, MD; Centre for outpatient treatment of drug addicts, M. Gioseffi 2 - 52440 Porec, Croatia

the war situation and the war-related crime, but at least it was clear what should be done. Conversely, the fall in demand was something about which nobody knew where to start and what to do.

Methadone was available as one of the options, but for the government it was extremely controversial, because it was considered to be highly suspicious by the 'moral authorities'.

Finding itself holding a 'hot potato' and not knowing what to do, the government decided to do anything. They left the problem to medical specialists and experts, without making any announcements or setting up any regulation!

Fortunately that was the best solution for Croatia.

Introduction of methadone in treating addicts, 1991

In Croatia methadone for the treatment of addicts was introduced through the "slightly open door".

As an opioid analgetic for sever pain, mostly in cases of cancer, it has been widely prescribed for more than 30 years, but at first the idea of using opioids as a medicine for opioid addictions, seemed unimaginable. Methadone was often misused by heroin users as a "substitute", which raised the question "How can a medicine which is abused and is considered illegal be used as a therapy against addiction?" Over a long period heroin addiction was not a major public health problem, so people did not even have to think about it. But the problem grew, and the need for new treatment options became irresistible. The first to understand the new situation and the new position of methadone was Dr. Sakoman, the head of the Department for Drug Abuse at the Sestre Milosrdnice University Hospital, Zagreb. Founded in 1970, this department was the first of its kind in former Yugoslavia. He used methadone first for inpatient detoxification. But inpatient use has never been called into question. It was outpatient use that was questionable! In 1991 the first inpatients were discharged, and referred back to their own doctors for the completion of methadone detoxification. Without exception, it was a success! The door was opened and methadone was on the scene!

How was it possible for such a controversial therapy to be introduced without any official approval?

Without considering the sociological setting, which is important in itself, some of the following factors may provide part of the answer:

- As methadone treatment was not officially approved, there was no reason to start a debate about it in the social, political or medical communities; that meant there was no significant opposition.
- In the early 1990s, GPs, who took on most of the responsibility for initiating MT, were still on a state salary and were practically obliged to accept all the recommendations that reached them from hospitals within the health system.
- Methadone treatment came in as part of detoxification programmes, and was seen as "temporary therapy". Initially the term "substitution" and "maintenance" were

not used.

- The personal influence of Dr. Sakoman in introducing methadone and promoting a humane, public health approach for heroin addicts was decisive.

Most importantly, addiction was treated as a medical problem, so that “addiction is like any other disease” and “methadone is like any other medicine”.

As with any other disease, therefore, there were no printed programmes with strict rules, only the following principles that have been left intact so far:

- Methadone should be offered and provided to anyone who needs it.
- No selection criteria for entering the programme. Age, period of addiction, and history of failed treatment attempts should be part of the input for inclusion or assessment and never stand as criteria for exclusion (i. e. age under 18 is generally not recommended for MT, but under certain conditions is acceptable).
- Practically no discharge policy. Illegal opioid consumption is not a reason for discharge. Discharge can happen as an “individual event”, not as a consequence of the policy.

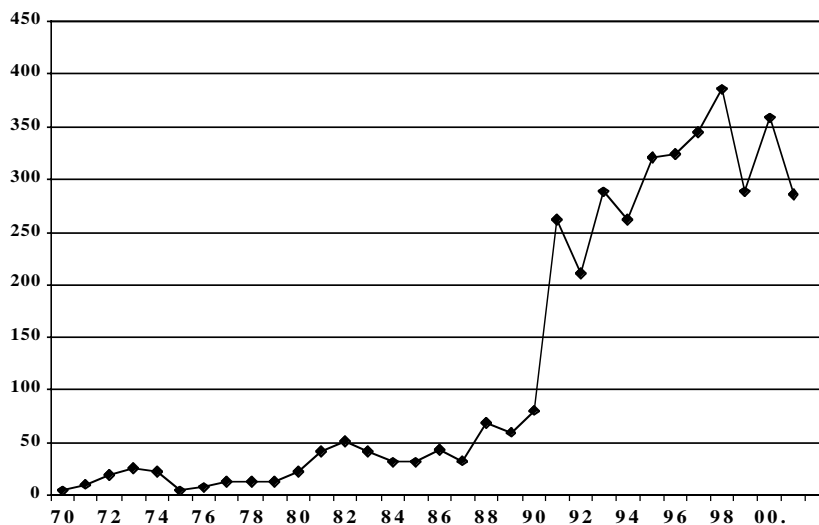


Figure 1. Opioid patients treated for the first time (1970-2001) in the Centre for Addiction at the Seste Milosrdnice University Hospital, Zagreb, Croatia

With permission from: S. Sakoman, "Drustvo bez droge (2002), Ivo Pilar Istitut, Zagreb

Implementation phase: 1991-1996

Once started, M T quickly brought a dramatic change in the treatment of addicts. Discussions and arguments started, but nobody could “push the genie back in the bottle”.

In a couple of months the first few hundreds of addicts entered the programme; by the end of 1995, over 1500 had been treated. There were no significant problems in prescribing and dispensing methadone, but it became evident that centralized methadone induction was insufficient and needed to be changed. Finally, in 1996 the Croatian Parliament approved the “National strategy for drug abuse control”, the first document to be issued on the prevention and treatment of addiction, and on limiting the supply of illegal drugs. The “National Strategy” was not a law, and did not oblige anyone, but it was the first document to indicate government support for programmes that had already been operative for over 5 years!

On the topic of treatment, the “National Strategy”, in practice, described programmes that were already in place, and emphasized the recognized principles of treatment. The crucial innovation was the idea of establishing “Centres for outpatient treatment” in all counties and bigger towns, with the aim of helping to set up specialized units and enhancing the availability of treatment.

The early phase: 1996-2001

After 1996, Centres for Outpatient Treatment were established in all the areas facing drug problems; so far there have been 15 of these.

Again, it was not the central administration that decided on this important step, but local communities, who took the initiative and provided the funding. Due to lengthy political confrontations, it took a full five years after the publication of the “National Strategy” for the “Law on Drug Abuse” to be passed, and that only happened after many compromises and inadequate solutions (6).

Current situation and comments

Nowadays methadone treatment in Croatia is well established, and, despite all the problems, the programme is receiving widespread approval.

The three cornerstones of the programme are :

1. Network of Centres for outpatient treatment

Centres are the focal points for outpatient treatment. On the basis of a clinical assessment they may administer methadone, decide starting doses, type of treatment regimen, suggest supplementary medication, provide psychosocial counselling, do evaluation and collect epidemiological data.

Centres employ interdisciplinary teams comprising practitioners, psychologists, social workers and medical nurses.

Psychiatrists are usually responsible for Centres, but other specialists or general practitioners may be put in charge after receiving additional, mostly informal education. Non-psychiatric directors seem to do their work as successfully as psychiatrists and are equally acceptable to patients and colleagues. Apart from the fundamental principles already stressed, there are other factors influencing the efficacy of Centres :

- Accessibility. Centres have been set up in all cities that face an addiction problem, usually at convenient locations.
- There is no waiting lists for entry.
- All services, including psychosocial counselling, are free of charge.

2. General practitioners prescribing and dispensing methadone

There are no inpatient methadone centres in Croatia. Methadone treatment is, therefore, decentralized thanks to GPs, who have taken on the hard task of managing MT. The philosophy of considering methadone to be “like any other medicine” could only have been made effective “on the solders” of GPs. After an assessment at a Centre, an addict is referred to his or her own doctor, who then continues to prescribe methadone, and not only prescribes it, but dispenses it!

A doctor or a nurse has to get methadone from a pharmacy and provides it for consumption, usually in the form of daily supervised consumption in the office. Moreover, for take-home doses a nurse has to prepare a solution, as no methadone syrup is obtainable in Croatia: that means methadone tablets must be crushed and mixed with juice (which usually has to be procured by the doctor!). An intense, well-distributed 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 clear majority of doctors are favourable to MT, and disagreements are rare.

3. Good health insurance coverage

The services provided at Centres are funded at state level, and are completely free of charge; methadone dispensing is available to virtually any addict who has direct access to health insurance.

Even if not initially insured (but most of them are), heavy addicts will be able to obtain full insurance because of their addiction.

These safeguards have had a strong impact on access to, and retention in, the programme.

Problems and obstacles

MT has become an indispensable achievement of the Croatian health and social system.

The obstacles encountered so far have been insignificant, but they are growing and are beginning to threaten the basic principles of the programme.

- **“Traditional” drug-free orientation.** Even when it is unreasonable, there is an

Table 1. Drug (Heroin) Addiction situation in Croatia	
Population	4 500 000
Estimated Heroin Addicts	15 000
Heroin Addicts in treatment	7 000
on methadone treatment	3 000
on methadone maintenance	2 000

insistent demand for “less methadone”; it comes from providers, but also from families and addicts themselves! Addicts dislike the term “maintenance”, and prefer to express the thought by saying that they are on a “very long detoxification”. That fact influences many MMT outcomes.

- **Lack of rules for methadone treatment.** When MT was first introduced, the lack of rules played a historic role, but there is now a growing need, not for rigid regulation, but simply for a description of procedures and guidelines. The lack of rules is one of the reasons for dose diversion and the making of errors; incidents like these are misused in the media to undermine treatment programmes.
- **Payments to GPs participating in the programme.** The health authorities reject the idea of making extra payments to GPs for their hard work in prescribing and administering methadone, taking the idea of addiction being “just another disease” to an absurd extreme. GPs are paid on the basis of the number of their patients, receiving 134 kunas per year (about 17 euros) per person per year. This includes complete primary health services and, in case of an addict, daily supervision of his or her intake of methadone. In 2001 the Minister of Health refused a proposal to authorize the payment of about 25,000 euros per year to all GPs in Croatia who have patients on MMT.
- **Claims for centralization have their advocates.** The only argument in favour of the centralization of dispensing is that doses of methadone may be diverted. This idea springs from the intention to institutionalize PT by setting up a bureaucracy under political control.

Facts an indicators

To contextualize the situation in Croatia, table 1 provides some basic information.

Of 4,000 registered addicts not on methadone, about 800 live in therapeutic communities, 500 in prison, and over 1,000 are in a “drug free programme” – an expression referring to patients with a good contact with Centres and good social adjustment; most of these patients are employed or studying, and are abstinent or only rarely consume opioids (3).

- **HIV infection and AIDS.** Croatia has a low overall HIV infection rate, estimated

at 0.0015%. Only 171 AIDS cases have been recorded, from the start of the epidemic until 2000. The HIV infection rate among heroin addicts is 0.8 - 0.9% (2-4).

It is highly likely that these good figures are partly due to the availability of methadone.

- **Hepatitis rate.** About 50% of addicts are HBV or HCV positive (3).
- **Average dose** for those in MMT is estimated as 65 mg (3).
- **Deaths from overdose** in the last couple of years have been between 50-60 annually (4).
- **Diversion of methadone.** It is hard to estimate the proportion of methadone being diverted, but the price of methadone on the black market, which is 10 times higher than it is in pharmacies suggests that it is not substantial – 30 euros for a 100 mg dose on the street and 3 euros in pharmacies. The fact that at most 10% of overdose deaths are attributed to methadone, strengthens that suggestion.
- **Retention rate** is estimated to be over 80%. Of 119 addicts in treatment at the Porec Centre, 99 (83%), are still in the programme (5).

Conclusion

Despite the lack of strict rules, or maybe just because of that, methadone treatment in Croatia is well established and is generally viewed favourably.

So far the obstacles to its use have not been significant and have never reached a level high enough to jeopardize the fundamentals of the programme.

The concerns expressed about the phenomenon of diversion seem to be exaggerated, while the claims put forward for better control and greater centralization are another name for a 'high threshold' policy, which could lead to poor availability and rising political control over what is a 'normal' public health problem.

References

1. Nacionalna strategija za suzbijanje zlouporabe opojnih droga. National strategy for illegal drug abuse control (1996)
2. Hrvatski zdravstveno statistički ljetopis za 2000. God. HZZJZ Zagreb. Croatian Health Service Yearbook 2000.
3. Sakoman S. (2002) Experience with methadone in treatment of addicts in Croatia WHO Workshop, Velen, Germany
4. Sakoman S. Društvo bez droge (2002) Institut "Ivo Pilar" Zagreb
5. Ivancic A. (2002) Izvješće o stanju ovisnosti na području Poreca
6. Zakon o zlouporabi opojnih droga (2001) NN 107/2001

