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Swedish Use and Misuse of the Dole & Nyswander Treatment

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Summary

For 23 years (1966-1989) Sweden had a National Methadone Maintenance treatment of opioid addicts, delivering 70-80 % vocationally rehabilitated patients, taxpaying citizens, with no drug abuse and a great reduction in mortality rates. This treatment was changed in 1990 into a short-term methadone program, resulting in numerous discharges for disciplinary reasons, a high mortality rate among the newly discharged and poor rehabilitation results. Politically, the short-term treatment is called "restrictive", which is regarded as commendable by the Swedish mass media.

Key Words: Maintenance vs. short-term methadone treatment

1. Introduction

During a one-year visit at the Rockefeller University in New York 1965-66, I had an opportunity to study the Dole-Nyswander treatment of heroin addiction at a time when the initial results were being published [3]. After returning to Sweden I set up a similar treatment system in Uppsala and for 23 years, beginning 1966, I was in charge of a National Swedish methadone program. I remained in contact with both these pioneers in addiction treatment for the rest of their lives and got many helpful suggestions from them on how to develop the Swedish program.

There are two different attitudes among therapists in this field, which may create problems. One is a severe repressive attitude (give them short-term treatment, and then they will have to manage as best they can). The other problem-inducer can be described as permissive benevolence (give them methadone and early retirement pension and let us then be spared the trouble of hearing from them). Both these attitudes unfortunately neglect the normalizing effect of methadone maintenance and both effect a message to the patient that "we are not willing to welcome you back as a normal citizen in our society". Naturally both therapist attitudes are learned, sometimes during early childhood, and therefore difficult to eradicate. Part of our own good treatment results may have been due to my careful supervision of unwanted tendencies and removal from the MMT program of colleagues with inappropriate reactions.

In my experience it is important to maintain a generous and hopeful view on this clientele and to point out to them that during methadone induction they have become fit for work and stimulate the acquirement of any reasonably well-paid job. These patients have lost many of their best years and it is essential for them to feel support and encouragement, rather than being subjected to time-consuming instruction in more or less sophisticated social or psychotherapeutic training programs, regularly with many elements of confrontational moralizing and punishment. In Sweden we have had during the last 20 years a development which is a good example of the first problem (severe repression), while other countries (the Netherlands, Switzerland and Denmark) are examples of a development into permissive benevolence, eventually leading to heroin maintenance treatment. Since both systems are harmful for the treatment results, it may be worth while describing them. Here follows a description of the Swedish development.

2. A National MMT 1966-89

For more than two decades the National Swedish methadone maintenance treatment (MMT) was subjected

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to political and mass media criticism, although functioning well and delivering a stable majority of 70 to 80 percent of our heroin addicted patients as vocationally rehabilitated taxpayers. We had a yearly patient retention between 80 and 100 percent and a mean 89 percent of the patients admitted during the first 23 years stayed at least a year in treatment. Although we had had the same frustrating experiences as other countries with the drug-free treatment of morphine addicts, who seldom managed to break their drug habit, only few cared to notice or comment on our results with MMT. Instead, there was a repeated slander of our efforts, which were said to be just a meaningless switch from one narcotic drug to another. In particular, the political attitude even in conservative newspapers favoured such views and the Swedish Radio described methadone as an invention by Adolf Hitler, who had sold the German patent to the American multi-millionaire John D. Rockefeller, who used it to eradicate the black race in Harlem of New York City. Among the hostile enemies of MMT was the National Board of Health and Social Welfare (abbreviated Board of Health), where a social worker became head of the Division of drug addiction and decided that drug addicts should no longer be treated by psychiatrists, but primarily by social workers. Being head of a psychiatric research unit at Ulleråker Hospital in Uppsala I could disregard most of the ongoing debate, but I needed some support from the Board of Health each time the MMT program had to be enlarged, otherwise I couldn't get the necessary resources, nurses, etc. from the county of Uppsala.

In 1973, when I realized that the Board of Health wished to get rid of our treatment program, I decided to arrange an open randomized controlled trial, comparing MMT with drug-free treatment of heroin addicts, 20-24 years of age, in a two-year study. To be able to monitor the outcome of this study, we applied a sequence analysis system[1], comparing MMT patients and drug-free controls pair-wise with respect to cessation of drug abuse, until a statistical difference was established between the groups. Before this study there had been three uncontrolled American studies of mortality rates [2, 5, 8] presenting altogether 14,250 heroin addicts in MMT and 14,250 in drug-free treatment, with no significant difference between the groups. Unless the results of our study enabled the Board of Health to support our efforts, I intended to close down the treatment program and while waiting for the opinion of a special evaluating committee, there would be no more patients accepted.

The outcome of our study unequivocally showed MMT to be superior to drug-free treatment. The sequence analysis had signalled significant group differences already after 17 patients had been randomized to each treatment group. After two years 71 percent (12/17) of the MMT patients were free of drug abuse and socially and vocationally rehabilitated, while the drug-free treatment group had only 6 percent (1/17). When the two years' study was concluded, ten of the drug-free treatment group reapplied and were admitted into MMT. After six years of observation there were 81 percent (22/27) who had become free of drug abuse and socially and vocationally rehabilitated. In the initial drug-free treatment group only seven remained, one who was still free of drug abuse and six subjects who were dead. This was the first randomized study clearly proving an advantage in survival rate for MMT over drug-free treatment. There was a committee of specialists elected by the Board of Health and the Medical Research Council to scrutinize the results and after a year they came up with a report which was unconvincing and wavering. Our study was considered to be too small and the entrance criteria were said to be insufficiently defined (a minimum of 4 years of intravenous heroin abuse around the clock as documented by hospital records, an age of 20-24 years and a minimum of three unsuccessful attempts in earlier drug-free treatment was not considered enough for the committee). When I presented the results at an international meeting in Stockholm, American participants were impressed and found the results very important. However, the newly elected head of the Division of drug addiction at the Board of Health, remained unimpressed and told me that "now we are going to get the patients out of your MMT programme".

As a result the politicians advised me to close down the programme. They were willing to pay only for the MMT patients already in treatment, but not for additional cases. But I told them "no, you can't have that". Either I had been unable to demonstrate efficacy and then the whole MMT should be closed down, or if the programme was efficacious this treatment must be given to all heroin addicts in need of it. Finally, after 5 years of mass media debate, the Director General of the Board of Health arranged a meeting with the irresolute politicians and declared that according to her opinion the MMT program had a proven efficacy. The politicians immediately surrendered and decided to support the program, but within the Division of drug addiction at the Board of Health it was decided to maximize the number of patients treated at 150. In 1989 I retired for age reasons as head of the Psychiatric Research Clinic in Uppsala and soon afterwards the head of the Division of drug addiction at the Board of Health introduced new instructions for treatment. It was decided that MMT should only be given for a brief period of time. Doctors should work to convince the patient that he/she could soon leave the treatment and patients should be informed of this policy before entering. At the same time the National MMT program was abandoned and a number of Drug addiction treatment centres were installed, where doctors were instructed to find out strategies to get rid of their patients. Presently there are 77 such treatment centres. At the same time we published a study of street heroin addicts (our 5-year waiting list) whose mortality rate was 63 times the expected for a group of Swedish citizens of that age and gender distribution, while MMT patients had a much lower mortality rate, 8 times the

expected. In that study we also demonstrated the rapid return to a street addict's mortality rate after involuntary exclusion from MMT [6]. I was asked to present this study at the Board of Health, but later they called back and cancelled the meeting, explaining that they could read it for themselves.

3. Short-term methadone treatment 1990-2009?

During the nineties the 77 new treatment centres came up with a number of harassment strategies. First, a patient could not be entered on the waiting list unless the social services had so decided, referral to treatment by a doctor was not enough. Patients sometimes had to wait for years before they were entered and after that followed a waiting for months on the list. Before the patients entered treatment, they must sign an agreement to let the police read their medical records. Although the length of treatment had not been specified in the recent Board of Health instructions, many centres decided to maximize treatment at 2 years. Patients were instructed to show up for their daily methadone or buprenorphine dose between 10 and 11 a.m. Those who came between 11 and 12 were given only half the dose and after 12 no dose was given that day. Our earlier patients, who had been transferred from the National program and who were carrying on a paid job, had difficulties to be punctual at the centre, but no exceptions were allowed for them. The nurses who delivered the dose could decide whether the patient looked red-eyed or tired and if so they threw out the dose in the sink, telling the patient that "you have probably been out drinking alcohol". Some centres introduced compulsory psychotherapy sessions, where patients were invited to ponder over the misery they had caused during their years of drug abuse. Several centres introduced zero tolerance to drug-containing urine tests, including tests positive for opioids. Certain doctors made themselves guardians of their patients and could then decide over the patient's money, which is distributed back to the owner in a token economy system, for wanted behaviour. The vocational rehabilitation results of the former National MMT were replaced by compulsory work (usually raking of churchyard walkways), with a risk of being excluded from MMT if they fail to come. The resulting attitude of the patients is to regard the treatment period simply as a temporary rest from the stressful street-life of drug addiction. After exclusion they go back to heroin. Few patients apply for a job any more, so vocational rehabilitation rates have gone down, from 80 percent in the National programme, to levels which are no longer recorded in evaluation studies.

As a result of the short-term, decentralized methadone and buprenorphine treatment systems, there are several treatment interruptions due to frequent involuntary discharges for disciplinary reasons and mortality rates are rising, particularly among recently discharged patients [4].

But politicians, both to the right and left, are pleased to notice that the Swedish treatment of addiction has become "restrictive". In an attempt to question this development we have recently published a critical article in Swedish [7] and presently the Board of Health intends to rewrite its instructions. At the moment we therefore feel that there is hope for the Dole & Nyswander [3] treatment to become reintroduced in Sweden.

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