

THE LIMITATIONS OF METHADONE AND DRUGFREE TREATMENT

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During a drug conference I attended in St. Petersburg some years ago a Russian psychiatrist said to me : “If we can prescribe methadone , the addicts will stop injecting themselves and we can stop the AIDS epidemic”. In view of my previous experiences I had to disappoint him.

In 1924 in Britain a governmental committee called the Rolleston Committee set some principles that have remained fundamental for the British approach to heroin addiction. Addiction to heroin and morphine should be regarded as the manifestation of a morbid state and not as a mere form of vicious indulgence. The committee recommended that morphine or heroin may properly be administered to addicts by medical doctors. At the same time thatn this committee was laying out guidelines for this approach, the United States Bureau of Narcotics had just brought about the closure of the last morphine -prescribing clinic s and was prosecuting doctors who attempted to prescribe for addicts.

In the mid-1960's the amount of addicts in Britain was increasing rapidly from the original figure of around 500 in 1924. Some doctors, general practitioners, were prescribing excessive amounts of heroin which their patients were selling off to create a “grey” market.

In 1966 the Brain Committe recommended to restrict the prescribing of heroin to specially licensed doctors who were working in hospitals or special clinics. From 1968 the clinics started to substitute the prescribing of heroin by methadone, first by injection, later there was a shift to oral methadone. (Woodcock, 1980, Hartnoll c.s., 1980).

Although methadone had the disadvantage, that it caused abstinence symptoms lasting not only a few days as is the case with heroin, but several weeks, it had many practical advantages as it could be administered once a day. This method of distributing methadone daily to substitute heroin was developed in the United States. Dole and Nyswander had published their successful treatment of heroin addicts with oral methadone. They considered heroin addiction to be a metabolic disease. (Dole and Nyswander,1967). The treatment was called methadone maintenance treatment.

Altogether methadone prescription was highly critisized, - some therapists called the large scale and life-long prescription of methadone the greatest social crime ever committed (Casriel and Bratter, 1974, Bratter and Pennacchia,1978) - and although forbidden in most countries, it was introduced in other countries. In the Netherlands it was prescribed to opium addicts from as early as 1968, long before heroin was used by addicts. Heroin appeared on the black market in The Netherlands for the first time in 1973. In Britain the clinics subsequently stopped prescribing heroin in favour of oral methadone.

Ten years after they had introduced methadone Dole and Nyswander admitted that taking methadone without any further support was not sufficient to rehabilitate addicts.(Dole and Nyswander, 1976).

It also became clear that the use of heroin or other drugs was not an illness in itself, but a symptom of an underlying problem. It also was evident that not everybody who uses heroin becomes addicted. Almost all heroin addicts used cannabis before they started to use heroin, almost all users of cannabis smoked tobacco previously; but not all tobacco smokers start to use cannabis, not all cannabis users start to use heroin and not all heroin users become addicted. In the families of addicts we often find traumatic situations in the families of origin such as incest, suicide, sudden death of a parent, admission to psychiatric hospitals and divorce (Aron, 1975). In a survey in the United States among 732 patients in treatment for drug addiction it was found that 55% of the woman and 29% of the men had incest contacts (Glover c.s., 1996). In a study of street addicts in Rotterdam using hard drugs was found that two-thirds had suffered from serious deprivation in their childhood (Prins,1995). Also trauma's in adult live can lead to addiction. (Kooyman,1999).

The use of drugs, alcohol or medicines to alleviate the psychological pain of traumas can subsequently become a problem in itself. In my opinion, addiction can be seen as an adjustment to exceptional circumstances by means of adaptive behaviour that has become uncontrollable. Addiction can arise when control over this behavior is lost. Addiction is no more of an illness than fever, although someone who is addicted can be considered as being ill.

The definition of addiction which follows from this is : Addiction is a self-continuing harmful process resulting from the loss of control over adaptive behaviour which then itself becomes a problem. (Kooyman, 1993, pag.46).

Addiction to drugs can be seen as follows :

A person is faced with a great problem.

He takes drugs and therefore no longer feels the pressure of the problem.

Instead of drugs methadone can be given.

The problem remains unsolved.

Instead the person can learn to ask for help in solving the problem and learn how to solve it with the help of others.

This is the aim of the drug free treatment.

In the Netherlands the current government policy is to accept addiction as a way of life for some people. It is the country where the Minister of Health recently agreed that programs could be started where heroin would be distributed to a total number of 750 drug users for a trial period following the Swiss example. This was decided notwithstanding the fact that the trials with heroin distribution in Switzerland cannot be considered as a valid experiment (Satel & Aeschbach, 1999). One of the reasons often not mentioned to start heroin distribution on top of methadone was that the wide scale distribution of methadone did not have a significant effect in reducing the harm caused to society by the addicts.

To obtain you some insight in what happened in The Netherlands the following personal experiences may be illustrating the course of events. Hopefully the mistakes, that were made in the Netherlands can be avoided in other countries.

I started the second methadone programme in the Netherlands in The Hague in 1969. The social worker of the programme was very good at finding jobs for the patients. Unfortunately, these patients were also very good at losing these jobs within a few weeks. It took our team one year before we finally decided to carry out urine checks. We discovered that all our methadone patients were also using other drugs.

During that time a group of ex-addicts from the re-entry programme of Daytop Village in New York had come to The Hague after their recovery to perform a play. This was the first time I had seen ex- drug addicts. I decided to start a therapeutic community realizing that abstinence from drugs was possible. I remained head of the methadone programme and could successfully refer patients from the methadone programme who were not able to stay clean from other drugs to this drug free therapeutic community called Emiliehoeve. If the patients of the methadone programme relapsed regularly into taking other drugs the methadone distribution was stopped unless the patients agreed to attend the daily introduction meetings for the therapeutic community.

Surprisingly almost all of them entered the therapeutic community after some weeks.

This situation remained until 1976 when the politicians in The Hague out of fear for the increasing number of black addicts, mainly immigrants from the former colony of Suriname, decided that methadone should be made available to these addicts even if they continued to use illegal drugs.

A group of Surinam addicts had squatted a house in which heroin was sold. The city authorities made a deal that they would provide methadone to them if they would leave the house. The addicts left the house, got their methadone and then squatted in another house.

This methadone programme was established separately from the existing methadone programme and was run by the City Public Health Department. At first, this programme was limited to black addicts only. Several months later after protests from white addicts stating that they were discriminated against it was open to all addicts. (Kooyman, 1984). In order to avoid problems with residents protesting about having a centre in their neighbourhood, the methadone was distributed from a special bus at several stops.

The aim of this programme was to try to normalize the life of the addicts in the hope that they would steal less. Soon other cities such as Amsterdam followed the The Hague model. (van Brussel, 1987).

These programmes for distributing methadone without any demands on the part of the patients became later known as "harm reduction programmes" as opposed to methadone maintenance programmes where the aim is the substitution of heroin for methadone.

The black market in the Netherlands did not disappear as a result of the prescription of methadone on a large scale to all addicts who requested it. Also most addicts were poly drug users. More than 60% of the clients of the Amsterdam City methadone distribution programme were using cocaine daily. The addicts were usually given low doses of methadone as they preferred it that way, so they did not lose the effect of the heroin they were continuing to take. Often is overlooked that heroin use usually only one of the aspects of deviant behaviour . Research in the Netherlands showed that 50 % of heroin addicts were involved in criminal behaviour before they used their first drug. (Jansen and Swierstra, 1983).

Because heroin is illegal there is a black market. The high prices of the drugs lead to theft and other criminal behaviour in order to obtain money. The drug sold are not pure and may be mixed with substances producing health risks. It is questionable whether prohibition solves more problems than it produces.

The nuisance caused to society leads to reactions expressed by politicians, such as :

Drug addicts should not harm or be a nuisance to others so we should :

- Lock them up
- Supply free drugs
- Force them to give up
- Shoot them (as they did in Red China - solving their drug problem by executing all addicts who did not succeed in giving up)

A more humane reaction is :

All addicts should receive treatment

Methadone seems to be a instrument to reach all addicts.

It is however questionable if methadone distribution reduces the nuisance to society, that it reduces crime.

Let us take a look at the situation in Amsterdam, the city with an extensive methadone distribution programme where methadone is provided by buses at different stops.

The Scientific Institute of the Ministry of Justice carried out research to study the effect on the reduction of crime of the Amsterdam City methadone distribution programmes.

Three groups of addicts were compared :

- A group from a low threshold programme where methadone is obtained from a bus without further demands.
- A group from the high threshold programme where the person is offered other services in addition to methadone and where urine checks are mandatory.
- A group not receiving methadone

The results of this study were (See table 1):

Methadone and crime

Programmes	High threshold	Low threshold	No programme
No crime	60%	33%	41%

Table 1

The people in the high threshold programmes were least involved in criminal activities (60 % not involved). Surprisingly, the clients from the low threshold programmes did worse than those who did not receive methadone at all (33% as opposed to 47% who did not get involved in crime). Furthermore: The clients of the low threshold or harm reduction programme profited more from their crimes and were involved in more complex criminal activities than those from the other groups. (Leuw, 1998).

The conclusion is that large scale distribution of methadone without pressure to stop using illegal drugs does not have a positive effect on criminality , the reverse may be true. Only structured programmes with sanctions regarding the use of illegal drugs have positive effects on criminality.

What are the alternatives to "harm reduction programmes" which are no more than suppliers of extra drugs to addicts?

If we want to get people off drugs, only highly structured treatment programmes with clear limits regarding destructive behaviour and drug use can lead to positive results (Bratter and Kooyman, 1981).

Highly structured programmes are not popular among addicts and their helpers

The therapeutic communities have a high drop-out rate.(De Leon and Schwartz, 1984).

Only about 25 to 30% of the residents finish the whole programme.(Kooyman, 1993).

Is methadone given in low threshold programmes without any demands on the addict attractive ?

Is does not seem to be so either.

In the Amsterdam City methadone programme for instance, it was found in a study in 1982 that only 70% of the daily doses were collected and that 53% of the clients stayed on the programme for less than 15 weeks and 32% for less than 4 weeks. (Driessen,1987).

So what is the solution to making the programmes more attractive?

Should we supply all addicts with free heroin (and cocaine?).

It is often argued, that harm reduction programmes do improve the physical health of the participants. While this is obvious the case in drug free programmes it is questionable if this is so in harmreduction programmes.

In a study in the Hague comparing participants of the methadone distribution programme with heroin addicts not using methadone, it was found that the only motivation for asking for methadone were drug problems not health problems, which were of a higher concern among the non methadone users. The outpatient groups were also compared with an inpatient group. The latter had more psycho-pathological and social problems (Eland-Goossensen,1997). In a study in

Groningen no significant difference was found between an outpatient methadone group and an inpatient therapeutic community group (Jongsma and van der Velde (1985).

Most residents of therapeutic communities in The Netherlands were in methadone programmes before their admission.

The effect of harm reduction programmes on HIV infection is doubtful. In Sweden, a country with a limited use of methadone HIV infections among drug users are rare. In Spain and Italy where methadone is widely prescribed in some cities, more than 70% of the addicts are infected. Harm reduction does not seem to prolong the life of addicts. In a follow-up study of 290 participants of the methadone dispensing programme in Maastricht 25% were dead 10 years later (Kaplan c.s., 1995)

Harm reduction programmes may in fact not reduce a lot of harm, not for addicts and also not for society. They do have an effect in having the addicts postpone their decision to stop taking drugs by an average period of five years. (Kooyman, 1993).

Are harm reduction programmes less expensive than drug free programmes such as therapeutic communities?

It is not widely known that the highly structured Therapeutic Communities have proven to be very successful in treating drug addicts.

The first 172 admissions of the Emiliehoeve Therapeutic Community in the Netherlands were interviewed two years after they had left the programme. The results were compared with a similar programme of the Essenlaan Therapeutic Community in Rotterdam and with a detox only group. Strict criteria for success were used at the follow-up interviews: from the day the residents left the programme : No hard drugs, less than only once a week use of cannabis, tranquillizers or sleeping pills. No alcohol problems. No drug related arrests or convictions, no subsequent treatment for addiction and no admission to a psychiatric hospital.

According to this criteria 32% of the Emiliehoeve group was successful compared with only 4,5% of the detox only group (Kooyman,1993). Some residents used drugs for a short period after they left and stopped later as it was apparently no longer attractive. When we look at the last six months before the interviews the success rate of the Emiliehoeve group is 49%, of the Essenlaan group 42% and of the Detox only group 16%.

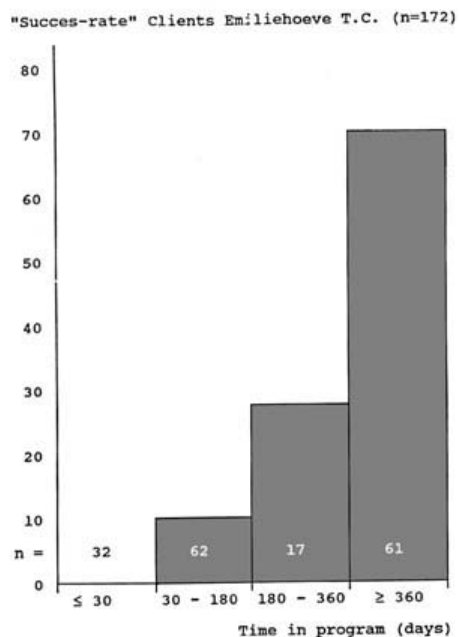


Figure 1

The succes is correlated with the length of the stay in the programme (see figure 1).

The only other factor clearly correlating with the succesful outcome was the participation of at least one parent at parentgroups. This effect was indirect, when parents were involved the residents stayed longer. (Kooyman, 1992,1993,).

A large number of the residents already leave in the first months to go back to drugs again.. Of those who completed the programme 80% to 90% were found to be succesful in different follow-up studies. The research of the seventies was repeated ten years later for Emiliehoeve residents giving similar results.

In-patient treatment has an image of high costs. The profits (money not spent for the persons while in treatment are usually ignored..

DAILY COSTS / BENEFITS

	No treatm.	Harm red.	Meth. maint.	Ther. comm.
Social	50	50	50	10
Medical treatm.	0	10	40	140
Crime related	150	150	60	0
Costs	200	210	150	150
Benefits	0	-10	50	50

Figure 2

Costs / Benefits in Dutch guilders

As you can see in figure 2 not giving any treatment at all costs 200 Dutch guilders per day: social costs (social allowances , other social costs such as shelters for sleeping, drop-ins) and crime related costs (arrests,detention, prisons, court cases etc). Damage done to society through theft, burglary and other crime is not included in the figure.

Methadone maintenance or drug free therapeutic community treatment both give a daily benefit of 50 guilders a day to those receiving treatment.

Harm reduction programmes are more costly than methadone maintenace (substitution programmes) or drugfree treatment in therapeutic communities. In addition to that many ex-residents of therapeutic communities have become tax payers..

DAILY COSTS / BENEFITS
AFTER THREE YEARS

	No treatm.	Harm red.	Meth. maint.	Therap. comm.
Success	10%	5%	25%	50%
Costs	180	199,5	112,5	75
Benefits	20	0,5	87,5	125

Figure 3

If we look at the results after a three year period (figure 3) we can see that the profits as a result of treatment are much higher when we consider the potential success. For therapeutic communities the profit is as high as 125 guilders per client a day. Therefore treatment is cost-effective and also cheaper than no treatment at all or harm reduction programmes.

Harm reduction programmes are expensive in comparison to treatment programmes that are cost-effective such as drug free therapeutic communities: this is even more so when heroin is given.

It is not clear what harm harm reduction programmes reduce.

Harm reduction programmes can never replace drugfree treatment modalities.

However, treatment in any form will never solve the drug problem.

Patients who are presently admitted to Emiliehoeve have a drug addiction history of an average of nine years . This is consequently five years longer than before the start of the harm reduction programme in The Hague that helped to postpone the decision to stop taking drugs.

Not all addicts can be treated in therapeutic communities and not all addict should go to a methadone programme. Both treatment modalities should not work independently but preferably together in the same organization.

Methadone substitution programmes and drug free programmes can both be part of the solution and can in my opinion work well together.

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