

## **Experience in work with centralized intake model (Checkpoints) for methadone substitution therapy in Dubrovnik**

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**Summary** – After the Homeland War, addiction in Croatia has raised to alarming proportions. The treatment of addicts is a long-term and very complex process and requires a wide range of biological and psychosocial methods with the support of local communities, but also the entire society so as to make sure that the process is even more successful. One of important factors in the approach to drug users is the need for a better control in treatment.

In Dubrovnik an experimental pilot-project was established with checkpoints (Punkt) for the implementation of methadone therapy. Despite the benefits in better controlling of drug addicts there were also a number of disadvantages, among which the most important was the high cost of treatment.

**Key words:** addiction; methadone treatment; checkpoints (Punkt)

### INTRODUCTION

One of the major problems in psychiatry is working with severe drug addicts (addiction to opiates – heroin, methadone, etc.). After the Homeland War, addiction in Croatia had taken on alarming proportions. The treatment of addicts is a long-term and very complex process and requires a wide range of biological and psychosocial

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methods with the support of local communities, but also the entire society so as to make sure that the process is even more successful. One of important factors in the approach to drug users is the need for a better control in treatment. One of important factors in the approach to drug users is the need for a better control in treatment.

Since the Second World War in most countries of the world, production, supply and consumption of alcoholic beverages, tobacco, psychoactive drugs and other illicit drugs has steadily increased. Misuse of these funds has become a trans-cultural phenomenon. Extensive work has been carried out all around the world to reduce this problem in all its levels and aspects.<sup>1,2</sup>

In a 5-year follow-up study carried out by Gossop and colleagues reductions in convictions for acquisitive, sale of drugs, and violent crimes were discovered.<sup>3</sup>

Scherbaum and colleagues confirmed that take-home dosages in maintenance treatment are of great therapeutic importance, but they include the risk of the substitute being distributed illegally.<sup>4</sup>

In randomized controlled trials carried out by Sees and colleagues it was noted that methadone maintenance therapy resulted in greater treatment retention (median, 438.5 vs 174.0 days) and lower heroin use rates than did detoxification.<sup>5</sup>

In the study of Connors it was noted that the sample of patients was overall slightly satisfied with methadone maintenance treatment.<sup>6</sup>

Until the development of the Glasgow supervised methadone program (1994.) it was common practice in the United Kingdom for methadone to be supplied to patients to take away for consumption elsewhere. The dispensing of a supply for a whole week or longer was commonplace and a supply for one month was not unusual.<sup>7</sup>

In 1994, when the Glasgow Drug Problem Service was set up, it was decided to actively promote the concept of supervised consumption of methadone in community pharmacies.<sup>8</sup>

During the middle 90-ies in UK was recommended by the British Department of Health's to increase the involvement of community pharmacists in the care of addicted drug users and to expand the range of services they offer to drug users.<sup>9</sup>

In their article Roberts and Hunter outlines the evolution of a community pharmacy-based supervised consumption of methadone program in Grater Glasgow. The formalization of this program in 1994 promoted full patient compliance with the methadone regimen and reduced seepage of the drug to the illicit market.<sup>10</sup>

In Croatia methadone for the treatment of addicts was introduced through the »slightly open door«. The introduction of methadone therapy can be divided into an implementation (1991.–1996.) and consolidation phase (1996.–2001.) 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 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.<sup>11</sup>

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. The three cornerstones of the programme are 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.<sup>11</sup>

## THE PREVIOUS EXPERIENCE IN THE WORK

Given the specific situation in Dubrovnik, though as in all Croatia at the end of 90-ies, there was a massive abuse of methadone for illegal purposes has started. The pressure by addicts on family physicians and the ability of addicts to obtain the methadone by prescription opened a »space« for massive abuse. As a computer system had not yet been developed in general practitioners and pharmacies addicts could visit more than one doctor in a day. They could collect large amounts of prescriptions and obtain up to ten daily doses of methadone a day.

The employees of the local Center have established, in support by the local community, centralized intake model with specially arranged checkpoints (hereinafter Punkt) as a pilot project. It was designed in order to better control the methadone intake. Punkt was opened from March to December 2002. It is important to note that there were no similar previous experience in Croatia, and we couldn't get to the relevant data of potentially benefits.

At the checkpoints there were two medical technicians and two security guards employed. It opened every day (apart from Sundays and holidays) for a period of two hours. Technicians collected prescriptions from family doctors and took methadone

at a pharmacy accompanied by security. Methadone was given dissolved in fruit juice. Addicts had to contact a psychiatrist in the Center who prescribed methadone.

## RESULTS

At the beginning of the checkpoint work, there were 131 registered opiate addicts, of which 113 (86.3%) of them were methadone treatment. In previous years, it was a very small proportion of addicts who have stopped with the treatment (1999 – 6 addicts, 2000 – 8 addicts). As it was discovered in 2001 that the checkpoint (Punkt) would start to operate 24 (18.3%) of addicts decided to stop treatment that same year and 37 (28.2%) in 2002. Among this addicts (61 addicts in total), a significant proportion of them have mostly used methadone for resale.

In the treatment of Punkt there were 52 (39.7%) opiate addicts registered at the Centre. 17 (13.0%) of them decided for treatment in isolation (commune, RETO-center), 60 (45.8%) were outside of any treatment, and 2 (1.5%) ended in death.

According to data provided by the city pharmacies, methadone consumption during the project almost halved (from the end of 2001 of about 4970 ml / month to 2842 ml / month in the end of 2002.)

## DISCUSSION

Considering that the duration of the checkpoint was relatively short, the data provided have no significant statistical value but are valuable as experience.

We found the similar way of implementing methadone therapy in the UK but it was based on supervised consumption of methadone in community pharmacies.

Luger and colleagues found that the clients stated as main advantages: local access, which saved them time and travelling, and the longer opening hours enabled them flexibility in managing their time. The main negative comments were related to lack of privacy when drinking their methadone within the pharmacy.<sup>9</sup>

Comparison of 2002 data from the Scottish Drug Misuse database shows that for the year although Glasgow has a higher level of persons reported to the database and the higher level of prescribing of methadone than is the case in Edinburgh (Lothian), it has the lowest level of persons reported as using illicit methadone.<sup>12</sup>

Lothian Health Board area has a much lower level of supervised consumption of methadone than is the norm in Glasgow yet it has a much higher number of persons reported as being addicted to illicit methadone.<sup>13</sup>

Supervision of the administration of methadone by community pharmacists has benefits beyond the prevention of »street leakage.«' The risks of loss or theft of the drug, bingeing, injecting, and overdose are minimised; trust between doctors and pa-

tients is enhanced; and as a reward for progress in treatment patients may be given more than one day's supply to take home.<sup>14</sup>

In the study of Mackie 12 community pharmacies in Dublin and 12 in Glasgow was piloted. In both cities the most common grounds for lack of service provision were business reasons, including risk to staff or property and theft, while the second most common reason was also related to business, in that pharmacists feared that »other customers would object«. <sup>15</sup>

We found that in previous years, very few drug addicts had stopped with substitution therapy (6 addicts in 1999, and 8 in 2000). At the beginning of checkpoint 61 addicts had stopped the treatment. A large number of them were taking therapy mainly for resale on the black market. 52 addicts remain on substitution therapy (39.7%). A better contact with families of addicts has been established and 13% of addicts have decided on treatment in isolation (commune, RETO-center). Given that the number of addicts who received treatment with better control therapy reduced so did the consumption of methadone by 1.75 times, or the number reduced by almost twice.

However, the high cost for maintaining the checkpoints and a number of disadvantages of implementing such treatment (long duration of collection prescriptions, the need for security, the need of work in two shifts in the summer months, inaccessible space obtained for this purpose) have led that the checkpoints to stop working at the end of December 2002.

In conclusion, we can conclude that the introduction of Punkt provides better control and records of drug addicts. The consumption of methadone is reduced by 1.75 times over a 10-month period, and thus reduces the »black market« for methadone. A better contact with the families of addicts has been established. Addicts were encouraged to visit institutional treatment (hospitals, Reto-centers, communes). The negative consequences of Punkt are additional stigmatization of addicts, the possibility of connecting addicts with criminal action, the high costs that the local community had to allocate for staff and a series of a lack of technical and spatial support.

## ISKUSTVA U RADU S CENTRALIZIRANIM MODELOM UZIMANJA METADONA KAO SUPSTITUCIJSKE TERAPIJE U DUBROVNIKU

**Sažetak** – Ovisnost o opijatima je nakon domovinskog rata u Hrvatskoj poprimila velike razmjere. Liječenje ovisnika je dugotrajno i veoma kompleksno te zahtijeva niz farmakoloških i psihosocijalnih metoda uz podršku lokalne zajednice, ali i cjelokupnog društva kako bi bilo što uspješnije. Jedna od važnih sastavnica u pristupu ovisnicima je potreba što bolje kontrole u liječenju. U Dubrovniku je 2002. godine eksperimentalno započeo sa radom Punkt za provo-

đenje supstitucijske terapije metadonom koji jes usprkos prednostima u pogledu bolje kontrole ovisnika pokazao i niz nedostataka, među kojima je najvažniji bio skupoća samog tretmana.

**Ključne riječi:** ovisnost; terapija metadonom; Punkt

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