

Methadone Maintenance in Europe and Hungary: Degrees of Sociocultural Resistance

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Opiate substitution treatment, commonly referred to as maintenance treatment, was introduced in the United States and Europe in the 1960s. This column discusses approaches to opioid maintenance treatment in Europe and focuses on the introduction of methadone maintenance treatment in Hungary. Although persons have received methadone maintenance in Hungary since 1987, consensus guidelines were not adopted until 1998 and were not confirmed by the Hungarian parliament until 2000. Hungary encountered initial difficulties in introducing methadone maintenance, and it is hoped that Hungary's joining the European Union in 2004 will help to make opiate substitution treatment more widely available. (*Psychiatric Services* 57:776–778, 2006)

Opiate substitution treatment, commonly referred to as maintenance treatment, was introduced in the United States in the 1960s. Benefits of such a treatment approach are well documented, with different re-

search studies indicating positive effects on the risk behavior of intravenous drug users (1).

In Europe, three types of substitution treatment are available: methadone, buprenorphine, and dihydrocodeine (2). Substitution treatment first appeared in Europe in the late 1960s in response to emerging, and later expanding, heroin use (2–4). Countries in Europe may vary in how they emphasize the health, criminal, and safety factors related to substitution treatment, and they may also vary in when this treatment was introduced and to what extent (2). This column discusses approaches to opioid maintenance treatment in Europe and focuses on the introduction of methadone maintenance in Hungary.

Provision of opioid maintenance treatment in Europe

Supply- and demand-driven approaches are used in European countries in the provision of substitution treatment. Scandinavian countries (Norway, Sweden, and Finland) and Greece use a supply-driven approach—that is, the supply of methadone treatment is decided by the government without necessarily reflecting the demand (2). In countries that use a demand-driven approach (mainly the Netherlands, the United Kingdom, Denmark, and Germany), the supply reflects the demand for substitution treatment by opiate users.

The Netherlands and Sweden introduced methadone maintenance treatment in 1967 and 1968, respectively,

with no resistance to the initiation of this substitution treatment. However, in other Western European countries, such as Belgium and France, the initiation of methadone treatment was delayed by more than 25 years (1994 and 1995, respectively). In some Western European countries substitution treatment spread and increased (that is, in the Netherlands, United Kingdom, Switzerland, and Denmark). However, in other countries (for example, Sweden and Finland) substitution treatment has become an established treatment, but its growth has been limited by the implementation of strict admission criteria (2,5). The United Kingdom represents a special paradigm of substitution treatment with a well-known, British system of opiate treatment supplied by general practitioners and psychiatrists (6). The United Kingdom initiated substitution treatment with heroin during the 1920s. The heroin is prescribed by general practitioners, and currently there are believed to be around 500 individuals who use this kind of treatment in the United Kingdom today (2).

Although only two European Union member states (Greece and Ireland) report that methadone is the only form of maintenance treatment allowed by law, the availability of other substitutive drugs is generally limited in all European countries (2). However, France is an exception. In France buprenorphine treatment was introduced in 1996, one year after the introduction of methadone maintenance; however, currently buprenor-

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phine is much more widely used than methadone in France because of the concern about the safety profile of methadone. Another contributing factor to the higher use of buprenorphine therapy is that the manufacturer of buprenorphine seemed to have some arrangements with the French Ministry of Health concerning the pricing of the product. Accordingly, buprenorphine and methadone are actually at the same price point in France, whereas throughout the rest of the world, buprenorphine is twice as expensive (2). This cost difference has led to “drug-treatment tourism” from stricter countries like Finland. Approximately 150 Finnish opiate addicts fly frequently to Paris to buy their buprenorphine medication (5).

The organization of services for the delivery of methadone maintenance is different for each country in Western Europe. Generally there are three main forms of services: methadone is available through general practitioners or private doctors (Austria, Germany, Ireland, and Luxembourg), through specialized centers (Finland, Greece, Norway, and Sweden), or a combined practice of clinics and private doctors (Belgium, France, and the United Kingdom) (2).

Resistance to the initiation of opioid substitution treatment has historically been more pronounced in the former socialist countries of Central Eastern Europe. In 2002 there were 2.91 methadone clients per 100,000 inhabitants in Poland, 15.42 in Lithuania, 4.5 in Latvia, and .0 in Romania (7). Compared with rates in countries in the European Union, these rates are extremely low (for instance, 206 clients per 100,000 inhabitants in Spain, 145 in Ireland, and 96 in the United Kingdom in 1997).

In Central Eastern Europe, a distinction can be made regarding the degree of resistance to introducing methadone maintenance. Methadone maintenance was introduced quickly in Slovenia, Estonia, Latvia, and Lithuania, and resistance was particularly strong in Ukraine and Romania. Hungary occupies a position between these two groups, together with the Czech Republic, Slovakia, and Poland (8–14). Methadone treatment was certainly advanced in Slovenia because of

the groundbreaking work of Dr. Andre Kostelic and his associates in Ljubljana. This group worked with officials within their own government, in addition to having support from a number of public health and harm-reduction organizations (15).

In this column, we present the initial experiences with methadone treatment in Hungary, highlighting the conflicts that occurred between government authorities and professionals.

Resistance to the adoption of methadone in Hungary

Background

Hungary moved from direct Soviet influence to a more democratic society in the late 1980s. However, during this transition period, many of the repressive elements of the social order persisted. For example, during the transition, Hungary experienced a tightly controlled central government that had a strong influence over health and medical practice. One manifestation was a negative view of opioid substitution treatment.

The first case of methadone maintenance in Hungary was documented in 1987 when—in complete departure from previous practice—a foreign national who had already received methadone maintenance in his own country continued this treatment at his own request in Budapest in the addiction medicine department of Nyíró Gyula Hospital.

After 1987, there was a steady increase in the number of persons who received methadone maintenance treatment. As a result, in November 1993 the Ministry of Welfare requested that the Professional College of Addiction Medicine more clearly define the professional protocol for maintenance treatment. Despite this request, active collaboration on this issue did not begin until October 1997, immediately after the scandal that resulted when police launched an investigation of a patient undergoing methadone treatment and his psychiatrist, who provided the treatment.

Dr. Funk, the addiction medicine department, and the police

In October 1997 police appeared in the addiction medicine department of Nyíró Gyula Hospital, which was

headed by psychiatrist Sándor Funk. The police cited an investigation against a drug user and inspected the stock of methadone in the department. They also seized a list containing the data of more than 120 patients with different diagnoses who had been treated in the clinic since 1996. The next day Funk made a complaint regarding the illegal seizure of the list to the data protection commissioner. A week later the police arrested the doctor on suspicion of abuse of drugs and bribery and launched criminal proceedings against him. The police then seized the separate list of patients treated with methadone in the addiction medicine department.

A subsequent investigation found that the requirement of fair proceedings had been violated and that the Budapest police headquarters had repeatedly violated the requirement of constitutionality and legal security and the right to legal redress. In his investigation, the data commissioner found that the Police Act does not authorize the police to “handle the data of patients not suspected of having committed crimes, in the course of activity against drug-related crime.” He referred to one of his earlier positions in which he found that one of the basic constitutional rights of patients treated in psychiatric departments, the right to self-determination over information, is violated if they are involved in police investigations as suspects without well-founded suspicion. In his opinion, the police violated the basic principles of data protection a number of times in the course of their proceedings.

The affair was widely discussed not only in the press but also in professional organizations. These organizations issued a joint statement protesting the fact that “following confessions made under unclarified circumstances by a few patients, the police can take the attending physician in handcuffs from his workplace, order a house search and arrest, and that the slightest suspicion can be sufficient to humiliate a doctor before his patients and colleagues.”

In the end the criminal proceedings launched against Funk that lasted close to a year were terminated by the prosecutor’s office without raising charges. Funk then sued the Budapest

Police Headquarters for compensation and won. However, the consequences of the police action have had repercussions for opioid substitution treatment in Hungary; the number of patients in the hospital immediately fell after the appearance of the police.

Current methadone treatment guidelines in Hungary

In February 1998 a methadone consensus conference organized by the Professional College of Psychiatry was held in Budapest with the participation of a wide range of specialists. It was here that the protocol containing the professional guidelines for methadone maintenance was first adopted. These professional guidelines were examined again and confirmed by the Professional College of Psychiatry in 1999. Up to early 2001 the drug treatment centers that provided methadone maintenance followed these guidelines. In February 2001 the ad hoc methadone committee of the Professional College of Psychiatry revised these professional guidelines, and they were adopted by that body in a new form.

With the adoption of the professional guidelines for methadone maintenance, the demand rose for broadening the indication for methadone tablets then available and for introducing a new drug form (20-mg tablets instead of 5-mg tablets), which is more in line with the requirements for methadone maintenance.

In December 2000 parliament adopted a unanimous resolution approving the recommendation. "For a National Strategy for Reducing Drug Use," elaborated under the coordination of the Ministry of Youth and Sport, set out the introduction of substitution therapy (methadone, buprenorphine, and levo- α -acetylmethadol [LAAM]) as a short-term goal, in parallel with the launching and spread of other low-threshold services (needle exchange and party service approaches—that is, a mobile service to help participants of dance [techno] parties in case of toxic states or other difficulties or crises) and harm-reduction programs. The aim of the strategy was "to set up and operate at least one maintenance therapy centre in each region over the short term." LAAM and

buprenorphine are not currently available in Hungary.

In Hungary by 2005 approximately 400 health care organizations were treating drug users. However, 88 percent of these do not deal with methadone treatment at all. Short methadone detoxification (two weeks) is provided by 6 percent of the organizations, long detoxification (12 weeks) is provided by 2 percent, and maintenance treatment is provided by 4 percent in specialized centers. Naltrexone treatment for opioid dependence is available in 4 percent of the organizations in specialized centers (16).

Conclusions

The difficulties encountered in the introduction of methadone maintenance in Hungary reflect the transitional society of the postsocialist countries. In Hungary, many of the adverse consequences of the change in political system can be found. Compared with the nongovernmental health care and harm reduction organizations of western European countries, similar Hungarian organizations do not have sufficient strength to exert political pressure on the authorities because of the contrary interest of the Hungarian government and political elite. In Hungary the social transformation was not as rapid and revolutionary as in the Baltic countries (Latvia and Estonia), where the impetus of radical changes made possible the rapid introduction of harm reduction for drug abuse. The drug issue has been politicized in Hungary to such an extent that political decisions on drug policy are made without professional legitimization.

Hungary joined the European Union in 2004. In the course of the development of uniform handling of drug affairs throughout the union, it is expected that the role of nongovernmental health care and harm reduction organizations will increase and professionalization of the drug treatment profession will accelerate. It is to be hoped that this process will also have a favorable influence on the governmental resistance to opioid substitution treatment and to the professional legitimization of methadone maintenance in Hungary and that it will help to make methadone maintenance

more widely available to patients in Hungary who can benefit from this treatment.

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