Dear Sir,

Methadone was introduced in the in 1991, the year the war has started and the year when Croatia as independent state was born. Paradoxically, the war probably facilitated the implementation of methadone. Having “bigger problems”, politicians accepted methadone without “typical” politically debate. In 1996 Croatian Parliament has brought the act that describe the conditions and the procedure of MT in the document called "National Strategy for Illegal Drug Abuse Control" (1). In 2001 was brought so called “Low on drug abuse” (5) that accepted MT as one of the treatment options as described in “National Strategy”.

The key premise of the Croatian approach is that drug addiction is not substantially different from any other chronic disease (alcoholism i.e.) . Consecutively addiction treatment is incorporated in existing health care system with GPs as key providers.

To enable rapid expansion and good accessibility, but ensuring expertise, a cooperation model between GPs and Centres for outpatient treatment has been established.

Drug addiction specialist in the Centre will decide if methadone treatment is required, recommend the dose, regimen and than refer a patient to his/her doctor who will:
- prescribe methadone
- provide supervised consumption
- procure the take home doses, if decided by expert in the Centre

So, there are no methadone distribution centres in Croatia, methadone is delivered exclusively by GPs offices. Out of 2400 GPs in Croatia, more than 1000 have heroin addicts in methadone treatment. (4)

The Croatian model is “low threshold”, there are no strict rules like: length of addiction, number of failed detoxification attempts, the maximum dose ,age etc.

Delivery of methadone is regulated to be mostly daily supervised consumption, but this regulation is adapted for every particular patient and “take home” doses are frequent.

Today, after almost 15 years of the implementation, the main indicators give no motive to change key points of the model.

Talking about reliability of the data must be said that Croatia has a “National registry ” of drug addicts driven by Croatian Public Health Institute since 1978 and annual report on drug addiction is issued for 25 years.(6)

Here are some basic information about drug addiction situation in Croatia:(2,3,7)
- Population: 4 500 000
- Heroin addicts estimated: 18 000
- Heroin addicts in any kind of treatment: 7 700
• New case annually 800-900, declining in the last years
• On methadone treatment 3000
• Overall drug addicts mortality 80-90
• Overdose mortality 50-60
• HIV infections rate at addicts 0,2-0,5 %, stabile or declining

Comments on the data:
- Overall mortality of addicts, taking in account the WHO-UNAIDS estimation of 2-3 % mortality annually, is low(8). It applies also for overdose mortality that is estimated to be half of the overall.
- the data on number of patients are from 2002, there same preliminary data that indicate that number of patients actually on MT is about 4000. (4)
- buprenorphine is in Croatia just registered and the experience is limited

General remarks and comments:
Working for more than 10 years in the field of addiction I am deeply convinced the results of MT in Croatia are impressive. Of course there are voices of unsatisfaction but, there has never been any serious initiative from any significant political person, institution, social group, or expert for changing the way MT in Croatia is organised.
The favourable indicators: number and tendency in new cases, overdose, HIV and AIDS rate at addicts, are certainly one of the main reasons.

Regarding the main concern – methadone diversion, Croatia has interesting experience. There is periodically public debate regarding alleged high diversion of methadone, but there is no evidence and no research to proof it. Of course, there is methadone diversion in Croatia, but for several reasons I believe not significant.
First, for unstable patients the supervised consumption is mandatory, second, take home doses are provided in the form not suitable for injecting and not suitable for selling (powder mixed with orange powder that makes the street price very low). But the principal reason is limited interest of the black market.
Having methadone widely available, no waiting lists, low threshold approach, no dose limits, methadone treatment practically free of charge, the main reason for diversion: demand is of the buyers is limited.
The buyers are mostly addicts who try to detoxify, or take a rest from heroin without “registering in the Centres”. So, if the methadone is diverted, it is usually not to get “high”, but for lessen craving and substitute heroin, i.e. for the same reasons methadone is used as a medicine!
There are practically no cases of primary methadone addiction. In the Centre for outpatient treatment in the Centre where I work, out of more than 260 heroin addicts so far there is only one patient whom illicit methadone was the first drug.

Regarding the question whether methadone - buprenorphine should be added “right now”, my opinion is, yes of course, even that there is still no WHO treatment guidelines. This are life saving medicines and in the countries with dramatically growing number of addicts that means saving great number of lives. Having methadone-buprenorphine on the WHO essential drugs list could be enormous, unimaginable support for substitution treatment advocacy and changing prejudice and prejudice is greatest in the countries with the greatest problem.
There is also a question: if diversion is the main concern, how would the future WHO guidelines influence possible diversion? Will it exclude diversion? Can any guidelines, or any regulation ever exclude diversion of the medicine that is extremely requested and extremely controlled? Guidelines itself will anyway not be sufficient and the local regulation would be necessary. The same applies for methadone diversion: local plans and projects will be necessary to meet local specifics. Waiting for the guidelines does not seems to be reason for postponing the decision if the other reasons are fulfilled.

Conclusions: Croatian experience is definitely example that in resource poor country methadone can be successfully implemented and used for betterment of the great number of patient and contribute to public health.

Hoping that my letter will give at least small contribution to the initiative, I am sending to you my best regards,

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