

After the Storm

Developments in Maintenance Treatment Policy and Practice in Sweden 1987–2006

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Introduction

The methadone conflict, which raged during the 1970s and 1980s, was a fascinating and important, but also tragic episode in the history of Swedish drugs policy. The consequences of the conflict were dire for a great number of drug users, many of whom died unnecessarily having been denied treatment. However, the Swedish view on methadone maintenance treatment (MMT) changed dramatically in only a couple of years at the end of the 1980s. The fear of an Aids epidemic contributed to a redefinition of the drugs issue to include the risk of contagion. Internationally this led to great drives to expand the MMT programs, but in Sweden efforts were initially confined to information campaigns and efforts to induce users to seek drug-free treatment. After a couple of years, when it was clear that more drastic action was required to reduce the contagion, the remains of the ideologically fuelled opposition could no longer prevent MMT from being accepted by a significant majority in the drugs policy field. In 1987 MMT had, after more than 20 years of disagreement and polemic, finally become accepted in Sweden.

I have described and analyzed the conflict over the MMT program in Uppsala in great detail elsewhere.¹ In this chapter I intend to outline what

¹ See Björn Johnson, *Policyspridning som översättning*, Lund 2003; Björn Johnson & Bo Hagström, "The translation perspective as an alternative to the policy diffusion paradigm: the case of the Swedish methadone maintenance treatment", *Journal of Social Policy*, vol. 34(3), 2005; Björn Johnson, *Metadon på liv och död*, Lund 2005; Björn Johnson & Bengt Svensson, "Metadonkonflikten", in: Verner Denvall & Bo Vinnerljung (eds.), *Nytta och fördärv*, Stockholm 2006.

happened afterwards – how maintenance treatment in Sweden went from being a marginalized form of treatment for a limited number of older chronics to become the dominant form of intervention against opiate addiction. In 1987, the Swedish MMT program comprised just over 150 patients. Twenty years later some 2,700 people undergo maintenance treatment in Sweden, 1,200 of which receive methadone and 1,500 the newer substance buprenorphine (Subutex).² In this chapter I will discuss the reasons for this development.

The following section gives a brief outline of the background and functionality of MMT, followed by a summary of the main events of the Swedish methadone conflict, as well as causes and effects. This will be followed by a section describing the “calm after the storm”, a consolidation phase roughly spanning a period of 11 years between 1987 and 1998. This period was characterized by an increase in heroin abuse and a slow, steady growth in the number of treatment places, but also a move towards a stricter, more disciplinarian attitude towards the patients and deteriorating treatment results. Then comes a section on an “expansion phase”, covering developments from 1999, when buprenorphine was introduced as a means of treating addiction, until today (January 2007). The expansion phase has been characterized by an increased interest in “evidence-based” practices in addiction treatment and also by a partial deregulation. Deregulation has led to a comparatively rapid expansion in terms of new programs and number of treatment places, but also to a more heterogenous and diversified range of maintenance therapies on offer. The chapter concludes with a brief section on what the future may hold in store for maintenance treatment in Sweden.

² The data were taken from the national pharmaceutical register by Socialstyrelsen (The National Board of Health and Welfare) and Läkemedelsverket (The Medical Products Agency) for the period July 2005–June 2006.

The methadone conflict (1966–1986)

Methadone maintenance treatment (MMT)

Maintenance treatment with methadone is a method applied in cases of severe addiction to heroin or other opioids. Generally speaking, the point of the treatment is to help patients to quit their habit while also improving their health and social situation. Research has shown that the treatment should continue indefinitely since the risk of a relapse otherwise is very great.³ The treatment was developed in the 1960s by two US researchers, Vincent Dole and Marie Nyswander, both working at Rockefeller University in New York. The first scientific study of MMT was published in 1965, and was enthusiastically received by the US authorities.⁴ Heroin addiction was a serious and growing problem in the US, and as a result methadone clinics rapidly sprang up across the country.⁵

The treatment form also gained acceptance internationally, today to be found in some thirty countries, mainly in the Western World. Despite the fact that MMT is the type of treatment with the firmest foundation in research (when it comes to combating opiate addiction) it has often been subjected to criticism. In the US, the rapid expansion led to a deterioration in the quality of treatment as well as diversion of methadone to the black market and less robust social support for the patients. In the mid 1970s the authorities started feeling the heat, and hit back by introducing regulations affecting both the access to the drug and treatment practices.⁶ In Sweden the introduction of MMT caused, as we shall soon see, a ferocious battle with devastating consequences for opiate users in Sweden.

³ Jeff Ward, Richard P. Mattick & Wayne Hall, “How long is long enough? Answers to questions about the duration of methadone maintenance treatment”, in: Jeff Ward, Richard P. Mattick & Wayne Hall (eds.), *Methadone Maintenance Treatment and Other Opioid Replacement Therapies*, Amsterdam 1998.

⁴ Vincent P. Dole & Marie E. Nyswander, “A medical treatment for diacetylmorphine (heroin) addiction”, *Journal of the American Medical Association*, vol. 193(8), 1965.

⁵ Vincent P. Dole & Marie E. Nyswander, “Methadone maintenance treatment – a ten-year perspective”, *Journal of the American Medical Association*, vol. 235(19), 1976.

⁶ Dole & Nyswander 1976.

The Swedish methadone conflict

MMT was introduced in Sweden as far back as the autumn of 1966, directly imported from the US by Lars Gunne, a professor of psychiatry who had been a visiting scholar at Rockefeller University.⁷ Heroin was an unknown quantity in Sweden at the time, but there were a few users addicted to other opiates, mainly morphine and raw opium.⁸ Consequently, professor Gunne started a small-scale trial at *Ulleråker's* Hospital in Uppsala. The program, which accepted patients from all over the country, was expanded as opiate abuse gradually increased toward the end of the 1960s. In 1970, some thirty patients, mostly older morphinists, had been admitted to the methadone clinic.

In the early 1970s the Swedish MMT program was subjected to fierce criticism. The opposing camp numbered, among others, representatives of the social services, the drug-free addiction treatment camp, *Riksförbundet för hjälp åt läkemedelsmissbrukare* (RFHL, The National Association for Aid to People Addicted to Drugs and Pharmaceuticals), and various other voluntary organizations. They voiced the opinion that methadone was a narcotic substance and therefore had no role to play in the Swedish addiction treatment services. A number of arguments were brought forward to the effect that MMT was a risky therapy, and probably detrimental to society, running the risk of causing increased drug abuse. The proponents of methadone – a group basically consisting only of the staff responsible for the treatment and their patients – for their part claimed that methadone was an effective medical drug, and that there was nothing to indicate that the treatment actually had shown any negative consequences.

One reason for the conflict had to do with reports of deteriorating maintenance treatment programs in the US and elsewhere, another that an increase in opiate abuse in Sweden had resulted in transformations in the target group. As long as MMT primarily concerned a small number of older morphine addicts, it had been tolerated, but once opiate abuse escalated with younger drug users also beginning to fulfil the admission criteria, there was a clampdown. However, without doubt the ultimate cause of the conflict was a fear of a medicalization of the addiction issue, emanating from competing so-

⁷ The account in this section is, unless otherwise stated, based on Johnson 2005.

⁸ Jan H. Erikson & Lars Gunne, "Morfinism", *Läkartidningen*, vol. 64(41), 1967.

cial and medical approaches to addiction.⁹ The expansion of a comprehensive care framework with treatment clinics, health centres and advice bureaus in Sweden centred on the social services rather than the medical ones as was the case in many other countries.¹⁰ In this context MMT stood out, as a deviant and a potentially dangerous competitor to drug-free treatment programs.

Throughout the 1970s the methadone conflict grew ever more intense and finally reached a climax around 1980. In 1979 admissions reached the 100-patient “cap” set by the regulatory authority, *Socialstyrelsen* (The National Board of Health and Welfare), in order to prevent too rapid an expansion. At that point, hoping to convince Socialstyrelsen to make the treatment program permanent and allow a great expansion of it, professor Gunne introduced a moratorium on new admissions.¹¹ However, it was to be several years before Socialstyrelsen had steeled itself enough to classify this treatment as one of “documented effectiveness”. When the moratorium was finally abandoned in 1984, the program directors found that half of the approximately 100 users on the waiting list for the treatment program had perished in the meantime.

During the first half of the 1980s opposition to methadone began to wane. The main reason was that the positive results achieved by the Uppsala program could no longer be ignored. After many vicissitudes MMT was finally classified in 1983 as a treatment of documented effectiveness – a step which meant that the patients’ home county councils should shoulder the financial burden of the program. However, Stockholm County Council, due to take the lion’s share of the costs, initially refused to put up the funds for the calculated costs of an expanded program. Only when Socialstyrelsen threatened to take action did the county council agree to pay up.

A more conclusive turnaround on the methadone issue was still a few years away, and then, as mentioned initially, connected to the spread of the HIV virus among Swedish heroin users, which in its turn fuelled the fear of a serious Aids epidemic. I will return to this in the next section, but first I would like to touch on the immediate consequences of the methadone conflict.

⁹ For a more detailed discussion of the medicalization criticism of the 1970s and the anti-psychiatry sentiments it rested on, see the chapter by Johan Edman in this volume.

¹⁰ Sven-Åke Lindgren, *Den hotfulla njutningen*, Stockholm/Stehag 1993.

¹¹ Lars Gunne, “Stopp för nyintagning till Ulleråkers metadonbehandling”, *Läkartidningen*, vol. 76(44), 1979.

The consequences of the methadone conflict

The eventual format of MMT in Sweden and the regulatory framework surrounding the therapy – some of it still in place to this day – was to a great extent a result of the methadone conflict. On a general level the opposition to MMT had the effect of greatly slowing down the expansion of this form of treatment in Sweden compared to other countries.¹² In 1972, Lars Gunne agreed with Socialstyrelsen on a number of criteria for admission to the treatment program; criteria which immediately ruled out a majority of the Swedish opiate users from participation.¹³ These criteria were later laid down by Socialstyrelsen, despite the fact that the program management had come to the conclusion that they excluded many drug users in sore need of MMT.¹⁴ Moreover, Socialstyrelsen also established a cap on the number of patients undergoing treatment at any one time, a limitation which from a medical perspective must be regarded as puzzling, but becomes more understandable when viewed from a political viewpoint. It was a concession to the opponents of methadone. In 1983 the cap was set to 150 patients, a mere five per cent of the Swedish opiate users at the time.¹⁵

On top of this should be added the fact that opposition to methadone within the social services meant there were few referrals and a small number of patients; at the local level social services spent much time trying to persuade opiate users *not* to seek methadone treatment. Many of the patients already admitted to the program found that they were often poorly received when contacting the social services, job centres and the psychiatric open care services. When it came to income support and job opportunities, for instance, these patients were seen as low priority, and within psychiatric open care they were simply refused admission since they were “under the influence”.¹⁶

¹² The account in this section is, unless otherwise stated, based on Johnson 2005 and Johnson & Svensson 2006.

¹³ Patients could not be younger than 20 years of age and had to have a documented (in the records of the social services) opiate addiction of at least four years' standing with several failed attempts at drug-free treatment. Furthermore, they could not suffer from any severe mental illnesses or be heavy polydrug users.

¹⁴ Socialstyrelsens författningssamling, SOSFS 1983:2.

¹⁵ Johnson 2005. In actual fact the percentage receiving MMT was even lower, since it took a few years before the number of admissions reached 150 patients.

¹⁶ See Lars Gunne, “Metadonpatienters rätt till psykoterapi”, *Läkartidningen*, vol. 72(38), 1975; Curt Åmark, “Klarläggande från Långbro”, *Läkartidningen*, vol. 72(35), 1975.

Problems such as these forced the MMT program to spend more resources on social curative measures. Among other things, they launched a psychiatric open care team, specifically for the benefit of the MMT patients. Having said that, one of the more paradoxical results of the methadone conflict is the very absence of any more fundamental changes in the treatment regime. In other parts of the world the dispersion of this form of treatment led to intense experimentation in order to find suitable therapies for patients with differing problem profiles and psychological stability. Nothing of this sort was seen in Sweden, where they more or less stuck to Dole and Nyswander's original treatment concept.¹⁷

The calm after the storm – consolidation and moderate expansion (1987–1998)

HIV–Aids redefines the drugs issue

As the risks of a major Aids epidemic become evermore palpable towards the mid 1980s, this spurred great healthcare campaigns internationally for various forms of contagion limitation. In an international perspective this led to a virtual renaissance for MMT (already from the beginning intimately connected to the medical approach to drug abuse) in many parts of the Western World. As previously mentioned this fear of an Aids epidemic also meant that attitudes toward MMT turned more positive in Sweden as well. Although opinion had begun to change as early as the beginning of the 1980s – mainly because it was no longer possible to disregard the positive results from the Uppsala program – it was the spectre of Aids that finally turned the scales conclusively in favour of methadone.¹⁸

This about-face was not immediate, however. When rumours of the new disease started spreading among heroin users in Stockholm during 1983–1984, many female prostitutes – convinced no one would dare buy sex with such a terrible disease raging – turned to Ulleråker asking to be put on the waiting list for the MMT program. However, since the program still was under an admission moratorium, none of them could be offered treatment.

¹⁷ Johnson 2003.

¹⁸ The account in this section is, unless otherwise stated, based on Johnson 2005.

The authorities freed up substantial economic resources to counter the Aids problem, but initially these resources were not used to fund any particularly radical measures or new ideas. Instead the authorities proposed to tackle the contagion in the injecting drug user community by seeking out users (in order to try and persuade them to seek treatment) and by expanding existing drug-free treatment measures.

However, as the number of infected drug users grew, they started to realize that the focus on visiting activities had failed to halt contagion rates. In January 1987, there were a total of 345 drug users diagnosed with HIV in the country, most of them heroin users in and around Stockholm.¹⁹ Among prostitutes addicted to heroin a staggering 80 per cent had been infected.²⁰ None of the heroin users had yet developed full-blown Aids, but it was obviously only a matter of time before people would start falling sick and die.

As a consequence also the ideologically driven attitudes toward MMT started to change at long last. Having been softened over the course of fifteen years, opposition weakened, and in 1987 Socialstyrelsen considered the time ripe for an increase in the number of MMT places. This was a clear sign that at least a partial redefinition of the drugs issue had taken place in Sweden. From having been viewed as a socio-political and legal issue for the greater part of the 1970s, addiction increasingly came to be seen as a medical problem.

New programs and stricter regulations

In March 1987, the Ulleråker clinic had some seventy names on their waiting list with an estimated waiting time for the last person on the list somewhere between one and two years.²¹ One of the organizations pushing most vociferously for a reduction in waiting times was *Läkare mot aids* (Physicians against Aids). This organization had been founded in 1984 by a group of doctors who were of the opinion that the new disease should be seen as a medical

¹⁹ Socialstyrelsen, *Granskning av metadonbehandlingsprogrammet*, PM 174/87, Stockholm 1987.

²⁰ Lars Gunne, "Politicians and scientists in the combat against drug abuse", *Drug and Alcohol Dependence*, vol. 25(2), 1990.

²¹ Socialstyrelsen 1987.

problem and handled by the healthcare services.²² Läkare mot aids reacted against what they saw as tendencies to a thoroughgoing politicization of the issue, and worked for an expansion of the MMT program and the initiation of needle-exchange programs.

The solution to the waiting time problem was to revoke Ulleråker's role as a unit with national admission and to convert the program's existing Stockholm clinic into a separate MMT program, the second in Sweden. Socialstyrelsen decided that Stockholm County Council henceforth would be responsible for methadone dosage adjustments, follow-up and aftercare for anyone living in the Stockholm area. Furthermore, it was decided that any Ulleråker patients from Stockholm by and by should be transferred to the new program. In a new decree Socialstyrelsen laid down the old admission rules, while at the same time announcing that they expected the programs to apply them relatively rigorously.²³

Socialstyrelsen's new decree caused outrage at Ulleråker. Lars Gunne voiced the opinion that he and his colleagues had been ignored when the new guidelines were drawn up. He also claimed that the HIV situation had rendered the old admission criteria obsolete, and that they had not applied them at Ulleråker for several years.²⁴ Gunne's indignation was in no way diminished when the director of the new MMT program, Stefan Borg, in an interview explained that from now on the long-term aim of the program would be to wean the patients off methadone.²⁵ In Gunne's view, both the experiences from Ulleråker and international research showed that only a tiny minority of patients actually managed to quit MMT altogether without relapsing. In all likelihood, Borg's statement was motivated by a laudable desire to further strengthen the positive attitudes towards methadone, so as to get the opportunity for further expansion of the Stockholm program.

In 1990 it was time for yet another methadone decree. Socialstyrelsen decided that MMT would also be available in Lund and the cap was raised to 450 patients. At the same time Socialstyrelsen established that also the *formal* long-term goal henceforward should be to get the patients off the treatment: "In the long run the doctor in charge should, in suitable cases,

²² Barbro Westerholm, "Kampen mot HIV och dess medicinska och politiska konflikter", *Socialmedicinska tidskrift*, vol. 67(4), 1990.

²³ SOSFS 1988:4.

²⁴ Lars Gunne, "Regler viktigare än människoliv", *Dagens Nyheter*, 30 June 1988.

²⁵ See *Socialnytt*, vol. 21(5), 1989, "Intervju med Stefan Borg".

work to help the patient quit MMT so that he or she can become drug-free,” wrote Socialstyrelsen.²⁶ There are two interesting things to note in all this: Firstly, Socialstyrelsen apparently considered methadone to be a narcotic substance rather than a medical drug, and that freedom from drug abuse and social rehabilitation was not enough in itself. Secondly, Socialstyrelsen – the regulatory authority for Swedish healthcare – seems not to have been acquainted with international research trends in addiction treatment prevailing at the time. However, the practical effects of the new treatment objective are hard to determine since it is unclear to what extent the new regulations were actually applied.²⁷

Sweden’s fourth MMT program saw the light of day in 1992, and was located in Malmö. In conjunction with the launch of these new MMT programs in the period from 1987 to 1992, a considerably more rigorous policy for patients with continued addiction problems began to be applied. Within the Stockholm program the aim of abstaining from illegal drug use was stressed particularly heavily, and a comprehensive control system based on the users repeatedly providing urine samples – sometimes several times a day – sprang up. Patients, gainfully employed and well rehabilitated, who had been transferred from Ulleråker were also forced to comply with these control procedures since the program’s directors “wanted an opportunity to get to know them.”²⁸ The new policy resulted in an increase in involuntary discharges due to relapses into illegal drug use.

The new and stricter regulations should in all likelihood be interpreted as a result of the program directions exerting self-discipline – even though the opposition to methadone had waned, it had by no means died off. In order to get permission to expand activities the program directions therefore had to prove that they were running a tight ship, which is why they quite simply got rid of patients unable to kick the habit.

The general view, both at Socialstyrelsen and at the county councils concerned, was that this form of treatment should only be used with the utmost caution and applied very restrictively. If not, they claimed, there was a risk of methadone being diverted on to the black market with criminality and

²⁶ SOSFS 1990:16.

²⁷ Official statistics mainly consist of the methadone register maintained by Socialstyrelsen between 1989 and 2004. A register account is available at <http://www.socialstyrelsen.se/Publicerat/2006/9139/2006-125-4.htm> (11 January, 2007).

²⁸ This has been confirmed by several of the patients that I have interviewed.

increased drug abuse as highly undesired consequences. This view was based on experiences from the US with its more liberal MMT programs. Diversion had quickly turned into one of the main arguments against MMT programs in the US in the 1970s. Ethnographic field studies from the middle of that decade painted a picture of how methadone had been integrated into and adjusted to the drug user environment and the street culture, and how it had become a street drug among active drug users.²⁹

In the US, the fear of diversion led to detailed regulation in various areas (at federal as well as state level), such as dosage levels, handing-out procedures and treatment duration. In all of these areas, the regulations came to harm the patients – suboptimal (insufficient) doses were prescribed, handing-out procedures enforced that rendered labour market rehabilitation impossible, and short-term treatment regimes implemented where patients, against their will, were forced to phase out their medication.³⁰ The outcome was low retention and unsatisfactory treatment results, while having little or no effect on diversion. A similar development could be traced in Sweden in the 1990s – somewhat paradoxically since methadone diversion of any significant magnitude never has occurred in this country.

An increase in heroin abuse and deteriorating treatment results

The expansion of the Swedish MMT programs was not only caused by a desire to improve access to treatment, it was also – or perhaps primarily – a consequence of an increase in heroin abuse. National surveys mapping the extent of illegal drug use, known as case finding studies, have been conducted in Sweden on three occasions. The first such study was performed in

²⁹ See for instance Michael H. Agar, “Going through the changes: methadone in New York City”, *Human Organization*, vol. 36(3), 1977. It should be noted, however, that the studies on methadone diversion conducted in the US have shown that the consequences of diversion in general are not as serious as previously thought. While there has been substantial diversion of methadone from the major programs, this has tended to be contained within more or less closed communities consisting of methadone patients and heroin addicts on the street. There are very few, if any cases where dissemination of the substance to new groups can be traced. For an interesting study of diversion, see Barry Spunt, Dana E. Hunt, Douglas S. Lipton & Douglas S. Goldsmith, “Methadone diversion: a new look”, *The Journal of Drug Issues*, vol. 16(4), 1986.

³⁰ Dole & Nyswander 1976; Marsha Rosenbaum, “The demedicalization of methadone maintenance”, *Journal of Psychoactive Drugs*, vol. 27(2), 1995.

1979 and indicated that there were approx. 15,000 heavy drug users in the country (in a range between 13,500 and 16,500 people). Out of this total, 30 per cent had used heroin or another opiate during the last year, but only 15 per cent claimed heroin to be their principal drug.³¹ In other words, in 1979 Sweden had approx. 2,250 heroin users.

The second survey took place in 1992, and showed an increase in heavy drug abuse. They now numbered around 19,000 users (range 17,000–20,500). The proportion who had used heroin had increased to 34 per cent, but much more worryingly this study evinced a growth in the number of users with heroin as their main substance. The figure now stood at 26 per cent, or some 5,000 people who could be counted as heroin users.³² This meant that the proportion who could be offered a place on a maintenance program had risen compared to the early 1980s, but by no means drastically. From a situation where five per cent of all heroin users had been offered MMT, by 1992 this had increased to just over seven per cent.³³

The rest of the 1990s saw a substantial increase in heavy drug abuse. In all likelihood this hinged on a number of cumulative factors, such as an increased supply of drugs, problems with segregation due to increased immigration, rising youth unemployment, public sector cutbacks, and a harsher social climate.³⁴ The survey conducted in 1998 – the latest case finding study – estimated the number of heavy drug users to 26,000 (range 24,500–28,500). The study also showed that heroin abuse had increased even further with 28 per cent stating heroin as their main drug (approx. 7,300 users). The proportion of users who had tried heroin in the last year was a staggering 47 per cent,³⁵ a clear sign that the patterns of drug abuse had changed since the 1970s. Polydrug abuse seemed to be the rule rather than the exception, and the number of users sticking only to their “favourite drug” seemed to be strongly on the wane.

Socialstyrelsen continued to raise the cap on the number of methadone patients as more patients were admitted to the programs, but development was tortoise-like all the same. In 1997, the cap was raised to 600 users and two years

³¹ Ds S 1980:5, *Tungt narkotikamissbruk – en totalundersökning 1979*, Stockholm 1980.

³² Orvar Olsson, Siv Byqvist & Gunnel Gomer, *Det tunga narkotikamissbrukets omfattning i Sverige 1992*, Stockholm 1993.

³³ According to the methadone register, only 360 methadone patients had been admitted to the Swedish programs by the end of 1992, despite the cap allowing as many as 450 patients.

³⁴ SOU 2000:126, *Vägvalet – den narkotikapolitiska utmaningen*, Stockholm 2000.

³⁵ Börje Olsson, Caroline Adamsson Wahren & Siv Byqvist, *Det tunga narkotikamissbrukets omfattning i Sverige 1998*, Stockholm 2001.

later to 800, but the programs still suffered from limited capacity. At the end of 1998, all in all 581 patients, or approximately eight per cent of the Swedish heroin users, had been admitted to the four programs. From an international point of view this was still a very low figure.³⁶

In this context it is worth noting that the Swedish MMT programs had started to display deteriorating results during the second half of the 1980s, a development that continued apace in the 1990s. For instance, the number of patients in gainful employment had nosedived to 20–30 per cent, admittedly from a remarkably high figure of 70–80 per cent in the 1970s. The number of patients with enduring addiction problems increased and retention rates dropped. In all likelihood, the deterioration in treatment results were caused by several of the circumstances mentioned above. It is true that the group of patients from the 1970s all were very heavy drug users, but the admission criteria in those days meant that the more serious cases of mental derangement and advanced polydrug abuse hardly ever featured. Having said that, the Aids issue made it all the more important to get as many HIV positive users as possible into the programs, and as a consequence the proportion of dual diagnosis cases and polydrug users went up. Since MMT naturally is more effective the “purer” the opiate addiction, this by force led to less positive results. The increasingly difficult situation on the labour market compounded the problem, since work or other gainful occupation is a fundamental feature of rehabilitation. Another potentially contributing factor to the deteriorating results was the stricter and almost police-style regulations applied in the new MMT programs.

The negative development throughout the 1990s is confirmed by a number of indicators, such as the number of drug seizures, the number of people treated for drug-related health problems and the number of drug-related deaths. The mortality issue was particularly alarming – drug-related deaths more than doubled in the 1990s. In the years 1989–1991 the mortality rate was just under 200 users per year. From then on the rate rose throughout the decade, reaching a peak in the early 2000s. During 2000–2002 some

³⁶ At the time, access to MMT was relatively limited in Finland and Norway as well. However, in countries like Germany, Spain, The Netherlands and United Kingdom access was substantially greater, while Denmark occupied a position somewhere in the middle. Comparative statistics for the proportion of opiate addicts undergoing MMT in the European Union is supplied by EMCDDA, see <http://www.emcdda.europa.eu>. See also Skretting's chapter in this volume for an account of the Norwegian development.

400 people a year died in connection with drug use according to Socialstyrelsen's cause of death record.³⁷ Since then, thankfully, the mortality rate has begun to decrease, which we will return to in the next section.

There were several reasons for the increased mortality: most importantly a rise in the number of heavy drug users coupled with a change in the patterns of drug abuse (more heroin, more polydrug abuse), but also factors such as an ageing population of drug users, more restricted access to drug-free treatment as well as a harsher social climate (hitting the most vulnerable sections of society the hardest), also played a part.

The increased mortality was not an isolated Swedish phenomenon, but rather part of a general development noticeable more or less all over Europe. In many instances this contributed to a reorientation of drugs policies and stimulated an interest in various types of harm reduction measures. In some countries, they managed to get the rate of increase under control relatively quickly, and even turn the mortality figures around. One of the most important reasons for this was the introduction of a substance that had been known since the 1970s, but only attracted the attention of researchers and physicians working in the field of addiction toward the end of the 1980s. In the 1990s a number of countries successfully started using this substance in maintenance treatment of heroin users. When it was introduced in France in 1996, for instance, they succeeded in reducing the number of lethal overdoses by a massive 80 per cent.³⁸ The substance was buprenorphine, but it has become more commonly known under one of its brand names, Subutex.³⁹

³⁷ CAN, *Drogutvecklingen i Sverige 2005*, Stockholm 2005. It should be pointed out that Socialstyrelsen's statistics comprise deaths where drugs are the direct, or *underlying*, cause of death (e.g. through overdoses) as well as deaths where drugs are counted as a *contributing* cause of death (where the underlying cause of could be anything from suicide to traffic accidents).

³⁸ Marc Auriacombe, Pascale Franques & Jean Tignol, "Deaths attributable to methadone vs buprenorphine in France", *Journal of the American Medical Association*, vol. 285(1), 2001.

³⁹ From now on I will use the term buprenorphine, unless I am explicitly referring to Subutex tablets or quoting other authors.

Toward “evidence-based” practices in addiction treatment (1999–2006)

Buprenorphine

When heavy drug abuse skyrocketed in Sweden in the 1990s, with a corresponding dramatic jump in drug-related mortality, there was no reaction at all initially – neither from the government nor from the authorities in charge, such as Socialstyrelsen. The official view was that Sweden had the best drugs policy in the world, which by default led to the assumption that the negative trend was due to factors outside their control – primarily the recent EU membership and the bad influence of “drug liberals” on the continent.

However, there was an increasing realization, primarily within the healthcare-based addiction treatment services, that there was at least a partial connection between the rising mortality rate and insufficient access to treatment and healthcare. The shortage of places in MMT programs was perceived as especially problematic. Socialstyrelsen kept raising the cap on admissions as the programs were expanded, so from a regulatory standpoint the major obstacle for a more rapid expansion was the admission criteria set up by Socialstyrelsen. The lack of healthcare resources was another hurdle; despite the fact that the admission criteria excluded the majority of all heroin users, the waiting lists for the two MMT programs in Skåne were several years long.

At that point a group of physicians and researchers at *Beroendecentrum Syd* (Addiction Centre South) in Stockholm began discussing the initiation of a buprenorphine treatment trial. When the new drug was approved by *Läkemedelsverket* (The Swedish Medical Products Agency) in 1999, the group quickly embarked on a research project aimed at developing and assessing a treatment model combining buprenorphine with intensive psychosocial therapy. 40 people aged 20 or above, all of them with a long-standing heroin addiction, were admitted to the project. However, the real common denominator was that none of them fulfilled the criteria for MMT. Half the patients were given buprenorphine combined with psychosocial therapy, while the other half only had access to psychosocial therapy. The buprenorphine group exhibited very positive results; after a year, 75 per cent were still participating in the treatment, and they displayed clear improvements in terms of drug use,

criminality and occupation. In the control group, on the other hand, all patients had interrupted treatment within two months.⁴⁰

The positive experience led to the word about the new drug starting to spread across the country. Socialstyrelsen was never involved when Läkemedelsverket approved Subutex, which resulted in the substance not being covered by Socialstyrelsen's MMT regulations. This in conjunction with the high demand meant that prescriptions snowballed, not least in the primary care services. According to *Apoteket's* (the nationwide pharmacy chain) sales statistics, Subutex sales increased fifteenfold between 2000 and 2005.⁴¹ According to Socialstyrelsen's calculations some 1,300 users were undergoing buprenorphine maintenance treatment as early as 2003,⁴² more than the total number of patients in the MMT programs.

The expansion of buprenorphine treatment, however, resulted in opposition flaring up anew in several quarters, primarily in the drug-free addiction treatment services and from certain voluntary organizations. When the number of heroin users in compulsory treatment started to drop, this was traced back to the prescription of Subutex: "In several *LVM* (Treatment of Addicts in Specific Cases Act, act on compulsory treatment) institutions we have seen a drastic reduction in the number of younger opiate addicts in the last six months. This gives us cause for concern as to how Subutex is administered and what control mechanisms are in place," the director of one institution was quoted as saying.⁴³ Similar criticism could be heard from, among others, *Föräldraföreningen mot narkotika* (Parents against Drugs), an organization categorically opposed to all forms of maintenance treatment.

Furthermore, some critics claimed that buprenorphine was a more dangerous substance than methadone. For example, two spokespersons for *Nykterhetsrörelsens samarbetsorganisation* (The Co-operation Organization of the Temperance Movement) in Stockholm and the lobbyist organization *Europe Against Drugs* respectively, wrote an op-ed where they claimed that Subutex was "a more potent narcotic substance than methadone" and that it could be abused. They then went on to say that "the effects of Subutex are more

⁴⁰ Johan Kakko, Kerstin Dybrandt Svanborg, Mary Jeanne Kreek & Markus Heilig, "1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden", *Lancet*, vol. 361(9358), 2003.

⁴¹ Barbro Engdahl, Anders Romelsjö & Marina Sand, *Behandling av opiatmissbrukare i Sverige med Subutex: 2000–2005*, Stockholm 2006.

⁴² Annika Engström, "Mycket effektiv behandling", *Svenska Dagbladet*, 18 June 2004.

⁴³ Caspar Opitz, "Tvist om medicin för heroinister", *Aftonbladet*, 11 November 2002.

short-lived than methadone” and that “the sought-after kick is more pronounced as well”.⁴⁴ It is true that Subutex can be abused (more about that below), but all other claims are incorrect, not to say altogether back to front.

Some opponents used arguments which were repeats of the most radical methadone criticism of the 1970s. For instance, the drugs coordinator at Örebro County Administrative Board wrote that the “handing out” of Subutex was just “another chemical straw in the pill-fixated haystack the pharmaceutical industry is trying to make us believe is the solution to anything from depression to ADHD and drug addiction”.⁴⁵ In another article some time later he continued his rant: “I suppose you could say that the healthcare services, in its pill-rolling symbiosis with the pharmaceutical industry, always have been part of the problem rather than the solution.”⁴⁶ The coordinator demanded that the county council close down the healthcare-service addiction center at Örebro on the grounds that “any normal alcoholic or drug addict [is no] more mentally ill than you or I. She will recover at all levels, resume all her mental faculties and is fully entitled to her own life, as long as she is given the help she needs to become drug-free. And that help has nothing to do with psychiatric care.”⁴⁷

Evidence-based practices and deregulation

It should be noted, however, that the arguments against buprenorphine never gained the same broad recognition in the early 2000s as the anti-methadone arguments of the 1970s. In all likelihood this was at least partly due to the developments in the patterns of drug abuse. Heroin addiction had become so widespread in the 1990s that the social services could not help noticing almost immediately the positive effects of buprenorphine treatment.

The type of anti-healthcare views evinced by the drugs coordinator at Örebro County Administrative Board also jarred when considering the general developments in treatment of drug addiction. Generally speaking, the view of drug addiction as a type of illness has gained an ever greater accept-

⁴⁴ Rolf Bromme & Katarina Cnattingius, “Ny medicin för heroinister kan missbrukas”, *Aftonbladet*, 17 July 2001.

⁴⁵ Börje Dahl, “Droger behandlas med andra droger”, *Nerikes Allehanda*, 31 May 2001.

⁴⁶ Börje Dahl, “Lägg ner Beroendecentrum”, *Nerikes Allehanda*, 20 July 2001.

⁴⁷ Ibid.

ance in Sweden in the 2000s.⁴⁸ This development has been paralleled by an increased interest in so called evidence-based practices in the treatment of addiction.⁴⁹ The report on treatment of alcohol and drug problems published by *Statens beredning för medicinsk utvärdering* (The Swedish Council on Technology Assessment in Health Care) in 2001 as well as the new guidelines for addiction treatment recently issued by Socialstyrelsen are clear signs of this increased interest.⁵⁰ The concept of an evidence-based practice can be seen as an indication of a continuing medicalization and individualization of addiction treatment, but probably also a symptom of more fundamental processes of transformation in society today.⁵¹ Among other things, evidence-based practices imply a certain methodology for evaluating social measures – randomized controlled studies (RCT) – getting priority before other methods. One of the positive aspects of this is that methods documented as ineffective are weeded out and that the room for decision-making solely on moral or ideological grounds is diminished. That being said, this development also carries a certain amount of risk. As therapy decisions become more expert-based the room for political control is reduced, and consequently diminishing the opportunities for democratic accountability. A one-sided focus on RCT data may also be detrimental to some potentially effective interventions which happen to be unsuitable for RCT validation.

During the early years of the 2000s various quarters began demanding Socialstyrelsen work out new guidelines for maintenance treatment. These demands were partly motivated by a dissatisfaction with the methadone guidelines, seen as too excluding and rigid, and partly by a fear that the relatively unregulated prescription of Subutex risked causing a diversion problem. Already early on, the appearance of Subutex on the black market

⁴⁸ Miki Agerberg, *Kidnappad hjärna*, Lund 2004.

⁴⁹ For discussions about the concept of “evidence-based” practices and its use in social work, see Anders Bergmark & Tommy Lundström, “Mot en evidensbaserad praktik?”, *Socialvetenskaplig tidskrift*, vol. 13(2), 2006. See also Mads Uffe Pedersen, “Drug-free treatment of substance misusers: where are we now, where are we heading”, in: Mads Uffe Pedersen, Vera Segraeus & Matilda Hellman (eds.), *Evidence Based Practice? Challenges in Substance Abuse Treatment*, Helsinki 2005.

⁵⁰ Statens beredning för medicinsk utvärdering, *Behandling av alkohol- och narkotika-problem*, Stockholm 2001; Socialstyrelsen, *Nationella riktlinjer för missbruks- och beroendevård* (referral version), Stockholm 2006. Both publications established maintenance treatment with methadone and buprenorphine as by far the most effective therapies against opiate addiction.

⁵¹ See Anders Bergmark, “Evidence based practice – more control or more uncertainty”, in: Mads Uffe Pedersen, Vera Segraeus & Matilda Hellman (eds.), *Evidence Based Practice? Challenges in Substance Abuse Treatment*, Helsinki 2005.

had been noted, and in the autumn of 2001 rumours of diverted Subutex began circulating, rumours which led to explicit demands that Socialstyrelsen tighten and regulate the conditions for prescribing the substance.⁵² At that point, Läkemedelsverket decided on a prescription collation from Swedish pharmacies, but this inquiry revealed no signs of incorrect prescription practices.⁵³ However, in 2003 there were further reports of an increased supply of illegal Subutex, inducing Socialstyrelsen to begin drafting regulations and guidelines for the prescription of Subutex.⁵⁴

Investigations into illegal Subutex use indicate this to be a common practice among drug users, but that the greater proportion of the Subutex tablets sold on the black market are used for self-medication by users who are looking to detoxify or undergo maintenance treatment on their own. Between October and December 2004 a survey was conducted where 473 injecting drug users, connected to Malmö's needle-exchange program, were interviewed. Just under half of them were heroin users, and of them a remarkable 89 per cent had used Subutex in the last year. 88 per cent of the Subutex users claimed treating withdrawal symptoms or detoxification as the main aim, not intoxication.⁵⁵ These findings are also supported by a study based on interviews and focus groups.⁵⁶ Often the respondents in the study were uncertain as to the origin of the tablets they had taken, but the results seem to indicate the majority to be of Swedish origin.

On 1 January 2005 Socialstyrelsen's new guidelines – identical for methadone and buprenorphine maintenance treatment – were introduced.⁵⁷ According to the new guidelines maintenance treatment should only be supplied by the addiction treatment services, and prescriptions only handled by psychiatric specialists. The MMT cap was finally lifted, and most of the ad-

⁵² See e.g. Opitz 2002.

⁵³ Fredrik Hed, "Korrekt förskrivning av Subutex i Sverige", *Läkemedelsvärlden*, 24 January 2003, available on <http://www.lakemedelsvarlden.nu> (11 January, 2007).

⁵⁴ See i.a. "Subutex ökar på svarta marknaden", *Göteborgs-Posten*, 27 January 2003; Kerstin Wigzell & Abit Dundar, "Behandling med metadon i hela landet", *Dagens Nyheter*, 25 May 2004.

⁵⁵ Anders Håkansson, Alvaro Medvedo, Magnus Andersson & Mats Berglund, "Use and misuse of buprenorphine among heroin and amphetamine addicts in Malmö, Sweden", Poster-presentation at Berlin Stapleford – 3rd International Addiction Conference on: Latest Developments in Effective Medical Treatments for Addiction, Berlin 18–19 March 2006.

⁵⁶ Eva-Malin Antoniusson, *Illegal Subutexanvändning – en undersökning av missbruket utanför behandlingsprogrammen*, Lund 2007.

⁵⁷ SOSFS 2004:8.

mission criteria were relaxed. The most fundamental change affected the requirement of four years of documented opiate addiction. This was shortened to two, motivated by a reference to international research.⁵⁸ Furthermore, the new guidelines facilitated launching new MMT programs locally. Previously this had required special permission from Socialstyrelsen, but according to the new regulations it was enough to submit a notice of the intention to open a maintenance treatment facility.

Expansion and diversification

The number of maintenance programs had started to increase even before the new regulations came into force. In 1999 there were only four MMT programs in the country (Uppsala, Stockholm, Lund and Malmö) with a total of approximately 600 patients.⁵⁹ In the early 2000s several buprenorphine programs were launched, and in the spring of 2003 there were a total of 14 centres providing such treatment. As previously mentioned, the number of buprenorphine patients were estimated at 1,300 for that year, but many patients received the drug on prescription from primary healthcare centres, i.e. without being involved in any program. By the autumn of 2004 another three buprenorphine centres had been established, and in the same year Socialstyrelsen approved a fifth MMT program, this time in Gothenburg. In December that year a total of 858 patients were enrolled in MMT programs throughout the country.

However, Socialstyrelsen's new regulations immediately spurred on a substantial increase in the number of maintenance treatment programs. In the spring of 2006 as many as 70 operations had submitted notices of their intention to run maintenance treatment facilities to Socialstyrelsen. All of them were based on buprenorphine treatment with some thirty of them also

⁵⁸ Research has shown that there seems to be an invisible boundary after roughly two years. Anyone who has been addicted to opiates for a shorter period of time than that is probably better off not being treated with either methadone or buprenorphine since the chances of breaking their addiction through drug-free treatment is relatively high. For users who have been addicted for more than two years, the prognosis is considerably bleaker, something which a Swedish study indicated as early as in the 1970s: Bó Frykholm & Lars Gunne, "Studies of the drug career", *Acta Psychiatrica Scandinavica*, supp. 284 1980.

⁵⁹ On 31 December 1999 there were 599 patients undergoing treatment according to Socialstyrelsen's methadone register.

with the MMT option on offer.⁶⁰ According to the latest estimate, based on Socialstyrelsen's and Läkemedelsverket's national pharmaceutical register, approx. 2,700 people were undergoing maintenance treatment between July 2005 and June 2006 in Sweden, divided on 1,200 methadone patients and 1,500 buprenorphine patients.⁶¹ In other words, the proportion of heroin users undergoing maintenance treatment have risen considerably since 1998. A rough estimate gives at hand that between 25 and 35 per cent of Swedish heroin users today can be offered a place in either a methadone or buprenorphine program.⁶²

The rising share of heroin users undergoing maintenance treatment has coincided with a reduction in the drug-related mortality. After peaking in 2000–2001, with some 400 deaths per annum with drugs as an underlying or contributing cause, the trend was broken in 2002, when 391 drug-related deaths were recorded. In 2003, the latest year for which data are available, saw the number of cases drop a little further, to 385 deaths.⁶³ According to EMCDDA's method of calculation – which only takes into account deaths where drugs have been a direct (underlying) cause of death – the reduction is more significant. Between 2000 and 2003 mortality dropped as much as 20 per cent, from 191 cases to 152.⁶⁴ After a closer look at the types of death behind the reduction, it quickly becomes obvious that the connection with the expansion of methadone and buprenorphine treatment can hardly be termed

⁶⁰ It should be noted, however, that most of these operations were very limited in scope.

⁶¹ These figures refer to the number of patients who have undergone treatment, *at some point* during that twelve-month period. This means that the methadone figure is not directly comparable to the data from the methadone register which indicate the number in treatment at year's end. It is nevertheless clear that the continuous increase in the number of methadone patients is still ongoing.

⁶² No case finding studies have been concluded since 1998, but according to estimates by *Brottsförebyggande rådet* (National Council for Crime Prevention) heavy drug abuse continued to increase slightly in Sweden between 1998 and 2001, and then began to decrease. The number of heavy drug users was estimated to 26,000 for 2003, which corresponded to the level in 1998. If the trend with an increasing proportion of heroin users has kept up it can reasonably be assumed that the number of addicts with heroin as their principal drug now range somewhere between 7,500 and 8,000 people. The data from *Brottsförebyggande rådet* were presented in updated form in SOU 2005:82, *Personer med tungt missbruk – stimulans till bättre vård och behandling*, Stockholm 2005.

⁶³ Source: Socialstyrelsens dödsorsaksregister, EpC.

⁶⁴ Mobilisering mot narkotika, "Kraftig minskning av dödsfall pga narkotika", Stockholm 2006, available on <http://www.mobilisera.nu/templates/GeneralPage.asp?id=4766> (11 January, 2007).

coincidental. The decrease can primarily be traced to the cases of acute toxicosis, i.e. overdosing.⁶⁵

What we have seen during the 2000s is, in other words, a relatively substantial increase in the number of maintenance treatment places. Opposition to this form of treatment has continued to diminish as evidence-based practices have gained wider interest. This development, however, has not been wholesale and there are still significant regional variations, both in terms of access and the psychosocial support services on offer, especially in buprenorphine programs.

In the latter case, the conclusion is that the treatment options have become more diversified. Access to psychosocial support differs between larger, big city programs and programs operated in smaller communities. Evidence-based support services such as cognitive-behavioural therapy and relapse prevention have become more common over time, but was still only offered at a third of the existing buprenorphine programs as recently as 2005. There are also significant fluctuations in dosage levels between different programs, despite the existence of extensive research on optimal dosage levels.⁶⁶

The approach to control measures varies as well. In certain programs urine samples are considered more important than the gainful employment of patients, and there are examples of patients who have been admonished to give notice because they are unable to get away from work in order to provide urine samples to the extent demanded by the program. In several programs a “zero tolerance” approach to relapses have started to creep in. This means that someone can be discharged after *a single* positive urine sample – a state of affairs that goes against Socialstyrelsen’s guidelines. In order to safeguard rights, Socialstyrelsen in response has issued a “handbook”, clarifying how the treatment guidelines should be interpreted.⁶⁷

There are also great regional variations in terms of access. Naturally, this is partly due to variations in the extent of heroin use, but can also be attributed to differing attitudes at social service and healthcare level. This has

⁶⁵ Attentive readers may have noted that the difference between Socialstyrelsen’s and EMCDDA’s methods of calculation indicate that the deaths where drugs are a contributing factor – deaths where heroin does not play as dominant a part as in the cases of toxicosis – have continued to rise. This is a further sign that the expanded maintenance treatment, and no other factor, really is having an effect.

⁶⁶ Engdahl et al. 2006.

⁶⁷ Socialstyrelsen, “Underhållsbehandling vid opiatberoende”, Stockholm 2006, available on <http://www.socialstyrelsen.se/NR/rdonlyres/BC0CD3B8-3CA2-4CE7-9C0F-67B91AEA529F/5390/20061015.pdf> (11 January, 2007).

been established in a survey, among other things, aimed at the Swedish buprenorphine programs in 2005, which showed that the proportion of patients referred via the social or healthcare services was 78 per cent in Stockholm County Council, but a mere 35 per cent in the rest of the country. The most common path by far to buprenorphine treatment in the rest of the country was through the users' own initiative; 57 per cent of patients outside Stockholm had sought treatment on their own volition (the corresponding figure for Stockholm was 17 per cent).⁶⁸

A study performed by Socialstyrelsen also indicate such differences in attitude. In the study some one hundred respondents, working in the social services and the county council treatment framework throughout the country, were asked to evaluate six "case vignettes", fictitious clients with various types of addiction problems. One of the cases concerned a 45-year old woman, homeless and working as a prostitute. She had been addicted to heroin for 15 years and had a large number of failed attempts at drug-free treatment behind her. In such a case the natural measure would without a doubt be to offer the woman maintenance treatment. However, of the respondents in the study only five per cent opted for maintenance treatment as their first choice, with a further eleven and nine per cent selecting this form of treatment as their second and third choices respectively.⁶⁹

Conclusion

Despite the regional differences described above it is nevertheless clear that the view of maintenance treatment has changed drastically in Sweden in the last twenty years. The debate today is not about whether these forms of treatment should be offered or not – as was the case during the methadone conflict of the 1970s and 1980s – but rather about access to and regulation of these therapies, and what demands to make of patients receiving methadone or buprenorphine. In this chapter I have shown that the driving forces behind this development are associated with changing patterns of drug abuse (mainly in the form of increasing heroin use and rising drug-related mortality)

⁶⁸ Engdahl et al. 2006.

⁶⁹ Socialstyrelsen, "Narkomanvård på lika villkor?", Stockholm 2004, available on <http://www.sos.se/FULLTEXT/103/2004-103-6/2004-103-6.pdf> (11 January, 2007).

as well as the ideational development in the field of addiction treatment (an increased medicalization in conjunction with a greater interest in evidence-based practices in social work in general).

As a conclusion to this chapter it feels appropriate to muse a bit on what the future holds for maintenance treatment in Sweden, both in terms of access and treatment practices. As regards *access* two problems stand out. Firstly, there still remains, in some quarters, an ideologically based resistance to maintenance treatment. This is primarily the case in county councils where heroin addiction is still fairly uncommon – a factor which, however positive in itself, is of scant little help to those heroin users who are unfortunate enough to live in the catchment area of such county councils. The second issue concerns resources: A number of maintenance treatment assessments conducted by social services have been disregarded, simply because there have been no places in treatment programs to offer. Over time the extent of these two problems will, in all likelihood, diminish. In November 2005 the Swedish Parliament decided on a national healthcare guarantee also intended to cover psychiatric care, a measure which ought to improve access in the long run.⁷⁰ Regionally, the new national guidelines for the treatment of drug abuse and addiction will most likely contribute to a more homogenized array of interventions.

However, a potential danger often broached when discussing maintenance treatment is the risk that the great demand for this type of treatment may lead to drug-free treatment options being forced off the road. This was one of the main arguments against MMT in the 1970s. In Sweden there is still very little to indicate that such a development is imminent, but it is worth noting that in a country like Denmark it is becoming ever more difficult for heroin users to gain access to drug-free treatment. Since there will always be heroin users who are unwilling to undergo maintenance treatment, a similar development must be avoided in Sweden.⁷¹

⁷⁰ See Jens Sjölander & Björn Johnson, “Läkemedelsassisterad underhållsbehandling av opiatberoende ett år efter den nationella sjukvårdsgarantins införande – en lägesbeskrivning”, report to Mobilisering mot narkotika, Malmö 2006.

⁷¹ Cf. also Johnson 2005, ch. 15. The high proportion of amphetamine users in the Swedish injecting addict community safeguards a continuously high demand for drug-free treatment, but if the development with increasing numbers of heroin addicts continues apace, there is a risk that in long run we will see a reduction on demand for these forms of treatment.

As regards *treatment practices*, a problem with the thresholds to treatment has been pinpointed; in many cases this threshold is so high that numerous drug users fall by the wayside before they have even been admitted into treatment. Demands are often made of the user to acquire permanent accommodation and to have a treatment plan in place with the social services before treatment is initiated. Many of them are furthermore forced to wait for a place in detoxification. However, recently a randomized controlled study was presented which lends support to a reformed and in fundamental areas simplified treatment strategy.⁷² The study, known as 3G⁷³, was based on a greatly simplified admissions process with a rapid treatment start. Drug users were taken “straight off the street” and were allowed to enter the pharmaceutical adjustment phase without detoxification. Another difference compared to conventional maintenance programs in Sweden was a decision to exclusively use positive reinforcement when interacting with the patients. Clean urine samples were encouraged, but contaminated ones did not incur any sanctions.

It is a known fact that methadone generally speaking is somewhat more effective than buprenorphine. The reason is that buprenorphine activates the opioid receptors of the body to a somewhat lesser degree than methadone, which may lead to the craving being less completely blocked. However, the results of the 3G study indicated that a stepped strategy where buprenorphine is used consistently as the first choice for the patients can be just as effective as methadone treatment. The advantage of this approach is that buprenorphine is preferable to methadone, since the former substance is less toxic, and therefore safer. In order for the stepped strategy to work as intended, however, it must be possible to rapidly transfer the patient to methadone, should not the buprenorphine treatment suffice.

Buprenorphine is used already as the first choice for most patients admitted to maintenance treatment, so in all likelihood the stepped strategy will have a great impact on the treatment of opiate addiction in Sweden. Nevertheless, it is hardly likely that it will be fully implemented; the issue of pa-

⁷² Johan Kakko, Leif Grönbladh, Kerstin Dybrandt Svanborg, Joachim von Wachenfeldt, Christian Rück, Bob Rawlings, Lars-Håkan Nilsson & Markus Heilig, “A stepped care strategy utilizing buprenorphine and methadone vs. conventional methadone maintenance in heroin dependence: a randomized controlled trial”, *American Journal of Psychiatry*, vol. 164(5), 2007, pp. 797–803.

⁷³ The term 3G is a reference to it being the “third generation” of RCT studies of maintenance treatment in Sweden.

tients with continuing addiction problems is still far too controversial in Sweden for a treatment strategy where drug-positive urine samples are allowed to pass unpunished to gain general approval.⁷⁴ However, a certain relaxation – in the form of greater tolerance for patients who suffer relapses – seems likely, not least considering the new guidelines and advice issued by Socialstyrelsen in recent years.

Translation to English: Ola Winfridsson

⁷⁴ This type of therapy exists in Denmark, but on the other hand they lack the psychosocial elements found in the Swedish programs.

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