

Research on the Danish heroin assisted treatment programme

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1. Presentation of me and the agenda for the presentation

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I am going to tell you about the project I am working on where I am researching the heroin assisted treatment in Denmark.

The possibility of offering heroin to people with a continued illegal opioid use despite maintenance treatment with methadone was made possible in Denmark in the spring 2008. I will give you just a short sketch of the Danish heroin programme so you know what we are talking about, in case you do not know already. This is not a full presentation (for this see...), but just to highlight some of the dimensions in the programme that is important for clients and staff.

Heroin is a second line drug; client should have tried methadone maintenance treatment without success before heroin can be offered. Client should have – despite the methadone – a continued used of illegal opioid which should be administered by injection.

Clients should not have serious, untreated mental disorders. Clients should be over 18 years old and pregnant women can not be part of the programme.

The heroin can only be administered by injection, that means no smoking, sniffing, eating, or via the rectum. Clients should be able and willing to come to the clinic twice a day, to take the heroin under supervision of a nurse and to administer the injection themselves, either intra venous or intra muscular. The heroin can be given up to two times a day – morning and afternoon, and methadone is given as a supplement for covering the client during the night.

The heroin treatment should be combined with appropriate psycho-social treatment.

Clients will need to go through a 10 to 14 days of supervised methadone treatment aiming at adjusting the dose before being transferred to heroin.

My presentation today will fall into three parts. First I will present the status for the programme for now, then in the second part I will present the research project. In the third part I will present a few preliminary findings from the clinics. But – I will underline – very preliminary as clients have only been enrolled since the 22nd of March – so approximately six weeks.

Until now twelve clients have started up in the clinic in the centre of Copenhagen, ten have started in heroin, one of these has at the moment one month of quarantine from the clinic and is back on methadone. The other clinic in Copenhagen, covering the periphery of the larger city has enrolled five clients, four have started on heroin. One of these is at the moment back on methadone because he had needed a little time off from the clinic, and the daily attendance.

Odense started up two weeks ago – seven clients are enrolled, four started heroin this Monday, three more are scheduled to start next Monday.

So one first important result is that people are not queuing up in front of the clinics to get free heroin as some critics of the programme had expected.

2. Presentation of the Danish research programme

Most of the research that until now has been carried out in connection to heroin treatment has focused on documenting the possible superior effect of heroin compared to methadone. And such a superior effect has been found in the projects. There are results from Switzerland, The Netherlands, Germany, Spain, Canada and Great Britain. In Denmark it was decided not to start the treatment with heroin as a trial, due to the positive results from the above mentioned countries.

This focus on effect has left a lot of more social and cultural questions concerning the heroin treatment un-answered. E.g. what do the drug users think of the treatment with heroin? Is the drug still considered desirable when it is to be administered under supervision of a nurse and in a more clinical setting? Can a ritual of hygiene substitute the ritualistic practices many drug users are applying when taking drugs at home or in more private settings? Can heroin be successfully transformed from a street drug to a clinical drug? How is it influencing their life – and drug use – that they will need to come to the clinic twice a day to take the heroin? Will this close attachment to treatment have a positive role on the clients or will they be institutionalized? Will the rather strict control and supervision in the clinics encourage clients to hustling and cheating or will it rather provide the clients with the desirable stabilization and more healthy practices concerning their drug use – or both?

Also when it comes to staff and the treatment institutions we do not know very much about how the treatment is carried out in practice. What kinds of dilemmas is staff facing in the everyday life at the clinics? What is the everyday life of the clinics; what is going on – besides the injection with heroin? How are the integration between heroin and the psycho-social treatment carried out in practice?

These are some of the most important questions that the research project is focussing on. The project has been initiated and financed by KABS (Copenhagen Drug Addiction Centre – the treatment institution covering the periphery of Copenhagen), but has also included the other drug treatment centres that are or will be offering heroin treatment. Next to this qualitative study we are working on a health-economic study of the heroin treatment. Finally the project has followed the political and public debate from the political decision to the actual establishment.

The projects are working with these six, broad, research questions:

1. How the treatment is planned, organized and executed?
2. What are the effects of the treatment – on clients and health economically?
3. What are the clients' perceptions of the treatment?
4. What are staffs' perceptions on the treatment?
5. How is the compliance of the clients?
6. How does the group of clients change and where do the clients come from?

Methodologically, the project is using mixed methods. The more quantitative part of the study will be based on questionnaires concerning self reported quality of life: EQ-5D and Drug users quality of life scale. These data will be supplemented with data from the clinics, with some of the data

collected by the national board of health, where among other things the presence of different disorders is registered. And finally will data from the national registers be used.

The qualitative part of the study is based on traditional anthropological methods: participant observation in the field – here the clinics, conversations with clients and staff regarding the treatment and the everyday life and open interviews on the same topics. All the clinics in Denmark will be included in the study. It is data from the qualitative part of the study I will end this presentation with. And I will hence ask you to please bear in mind that this to a large extent is an anthropological research project, focussing on social and cultural aspects of the treatment.

3. Results from the clinics

1. The clinics and the users

There seems to be in practice two different models for organizing the heroin clinics. One is to establish a heroin clinic on its own, a clinic that only handles clients enrolled in the heroin programme, which is what have been done in central Copenhagen. The client population in such a clinic will have that in common that they all are enrolled in the heroin programme. One of the challenges in this model is that staff needs to start from scratch developing practices on how to work with the clients. One could also speculate in that it might be more difficult for clients to shift to the heroin and back to the methadone as this demand not only a shift in medicine but also a shift in institution with the bureaucracy that follows and the risk for loosing important information about the client. On the positive side one could mention that staff will develop a joint expertise on the heroin treatment.

The other model for establishing the clinics is one where the possibility for injecting heroin is added to an already existing clinic for methadone treatment. This is the model chosen in KABS in the greater Copenhagen area and in Odense. Here heroin become one among several different preparations: subutex, oral methadone and methadone for intra venous administration. This principle is especially clear in KABS where the injection facilities are also used for IV methadone clients. The benefit of this organizing principle should be that the shift from methadone to heroin and back again should be smoother as the client can be in the same institution where staff knows him or her.

One of the challenges in this set up could be that clients on heroin will only constitute a small group among a lot of methadone users, which could lead to exclusion or conflicts. Also the general set up in the clinic is aimed at the methadone clients that only need to come once a day and the clients on heroin will have to fit in to this. One example on this is the opening hours in the centre. Several days a week the clinic closes around noon. This means that the clients on heroin can not stay at the clinic but will have to go somewhere else and come back for the afternoon injection.

When looking at the client group – they are off course just as different as any other group of drug users. But when it comes to their drug use it seems to be possible to place most clients in one of two groups.

One group is clients who through many years have had their own stabile systems with methadone and heroin. One example of this practice is clients who have been selling their methadone to finance a continued use of heroin. This is typical clients in the late 40s and 50s who have received methadone for many years but who still have the experience that heroin is their drug of choice. In

the clinic in Copenhagen several of these users are active in the drug users union. These users are – to use a word from the clinic – to a large extent ‘stable’.

Another, until now smaller, group are clients who have an active, ongoing use of drugs bought on the street next to their methadone. These street drugs are heroin, but also other drugs especially cocaine and benzodiazepines. Drugs – including the methadone – are injected if and when it is possible. These clients are less stabilized and some of them also have some behavioural problems in the clinics, described by staff as bringing street culture into the clinic.

One group of drug users that are missing from this categorization is the users on the boarder of society and hence the treatment institutions. The people living on the streets without much contact to the treatment system, the ones for example populating ‘the open drug scene’ in central Copenhagen. The hard to reach group. When it is relevant to mention this group is it because they were intended to be the central target group of the programme when the politicians first made the decision to offer heroin for treatment. Whether they with time will be able to find their way into the programme will be interesting to follow.

II. Dilemmas in the treatment

Changing perspective to the treatment there seems for now to be two central questions for staff to deal with. The first is a dilemma concerning how intoxicated by the heroin the clients are allowed to be. The second dilemma concerns the role of the psycho-social treatment in relation to the heroin.

a. How affected is it ok the clients are?

When visiting the clinics during the day time you can sometime find clients who are very affected by the drug taken. Some fall asleep, some sit in a corner with a happy smile concentrating on enjoying the effect of the injection taken. These clients prefer to be left alone so that staff do not spoil their enjoyment.

In two of the three clinics facilities have been made for clients to relax after the injection, the last clinic has decided not to.

To staff this intoxication raises several concerns or questions. The first is a rather simple concern to check weather the client is still breathing, when they are relaxing after the injection. The next question is one on how to work with clients so intoxicated. How to make a therapeutic intervention when the clients are stoned?

The intoxication of the clients leads to consideration if their dose of heroin is too high? The problem here then becomes that the pattern are not necessarily repeating every day. It is only sometimes that clients become very intoxicated – and not everybody does – at other times you can hardly see it on them at all. Clients themselves to a certain extend manipulate with the effect. By sometimes supplementing the injection with a pill or two or five they will add to the intoxication. Some clients are seeking this intoxication and have entered the programme to be able to have it. By lowering their dose of heroin they feel cheated, and think they have the right to supplement themselves to be able to reach the desired effect.

Having intoxicated people in the clinic can sometimes create envy in other clients that do not get the same effect. It is not unusually to here client saying, that he wants to get intoxicated the same way as another client, or that he wants the same drug, as this client has received.

What make these discussions somewhat different than discussions concerning methadone is, that the clients are used to take heroin to be intoxicated. Heroin is to a larger extend ‘their drug’ where the methadone to a much larger extend is related to the clinics and hence treatment. From a more philosophical or distance position one could ask whether it is possible to combine treatment with pleasure?

b. The role of the psycho-social treatment

The second dilemma concerns the role of the psycho-social treatment in relation to the heroin. There is no doubt about that heroin is the central element in the treatment. It can be seen in the official documents, f.ex. the guidelines from the national board of health, where most of the energy and space is devoted to the drug. It is the heroin and the injection that is in focus from the staffs’ point of view; it is here that something can go wrong, that it can be dangerous. And it is very much the focus of the clients; that is why they are at the clinics.

With a set up where clients can inject twice a day there is a potential for doing something else in the hours between. One challenge relates to the point above – can clients that are very intoxicated be treated? In the clinics where the set up is, that the clients leave between the two injections the question then becomes if treatment can take place in the ten to fifteen minutes that the clients stay after the injection. Some clients have mentioned that they think they already spent very much time in the clinics in relation to the injection that they find it hard to also find time for any more activities.

Another question that practice raise is what qualification is needed to do drug treatment? Can it be done primarily by nurses and nurse aids that the clients see in the injection facilities? This is maybe more a question of tradition and professional borders than on qualifications but it still needs clarification or settlement in practice.

III. Clients’ perspective

As you might remember one central question for the research programme is how clients perceive the treatment. I will end my presentation with some perspectives on this. First we will take a look at their perspective on the phase where they are being stabilized on methadone, and after that we will look at their view on the heroin after having tried it for some weeks.

a. On the stabilizing methadone treatment

As you might remember clients need to go through a phase to stabilize their methadone dose before they can be changed into heroin. All the clients I have met have expressed irritation and frustration about this phase. A few have – together with the frustration – voiced an understanding for the staffs’ perspective.

Clients see this phase as an unnecessary, bureaucratic control. Most of them have been on methadone maintenance treatment for many years and can not understand why they suddenly need to be enrolled in this control regime. They say that they think it is humiliating to go through this phase.

Others have expressed the position that nobody wants to die, so nobody will want to exaggerate the dose too much.

Others have suggested that they could just slowly in a few days time be given increased doses of heroin and thus adjust their doses of heroin to their level of tolerance at the clinic. That the clinics have the facilities that are needed to handle them if they get too much.

Some clients, that do not like methadone, and who for the most part have sold their methadone and bought other drugs find themselves trapped in this stabilizing period. As they experience that methadone is not working for them they need to get something else, but find themselves deprived of the source of income that have helped them to finance the use of street heroin. They therefore need to get the money from somewhere else in this period – f.ex. theft and prostitution.

And several of them complain that they actually need to find more money than usual, as they need higher doses of heroin to be able to feel it through the now higher dose of methadone they are taking supervised.

Also, some clients experience that the stabilization phase is stretching out in time. Either because the methadone dose needs further adjustment or because some health issues have not been settled or answered.

To most of the clients the stabilizing phase is also a time to build up expectations of how it is going to be, to get the heroin. In a guest book in one of the clinics one client wrote these notes the Friday and Sunday before he started on heroin on the Monday. The spelling mistakes in the Danish text are original:

19/3-10

Det bliver den længst wegent i hele mit lorte liv. Men jeg glæder mig helt vildt til på mandag.
Mvh

21/3-2010 Søndag DAGEN FØR

(Løsladelseskuller,) det er noget man får, dage op til ens løslades dato. (jule kuller) det er noget små børn fra 4 til 10-12 år, får af at vente på at julemanden kommer den 24-12 jule aften.

Gu ved hvad det heder det vi har, så. Stof trang? Nej, for vi var sylig skæve alle 5. 17 timer ca. Det ville blive en lang nat, Hvis jeg ikke hade haft 2 sovepiller til i aften. Og gud bevare danmark Hvis jeg sover for længe.

Mvh

19/3-10

It will be the longest week-end in my whole fucking life. But I really look forward to Monday.
Best

21/3-2010 Sunday THE DAY BEFORE

(To be excited before one gets released,) that is something you experience days before you get released from prison. (To be excited before Christmas) that is something small kids aged 4 to 10-12 years, gets while waiting at Santa Claus Christmas eve. I wonder what it is we are having? Craving? No, because we were really stoned all five of us. It will be a long night. If I hadn't had 2 sleeping pills for the night. And God save us all If I over sleep tomorrow.

Best

b. On the heroin treatment

This brings us on to the final part of the presentation – to the clients perspective on the heroin. Because the stabilizing period builds up an expectation that the heroin – when it comes – cannot really live up to – at least not in the beginning. Most clients to a beginning are dissatisfied with the effect. As one client put it: If you had sold me this drug of the street, I would have beaten you up. Besides this initial dissatisfaction every client, except for one, has chosen to continue with the heroin, so something must be right.

When I ask the clients what they think of the treatment some clients mention that they think it is boring. One said he was so bored, so he was sitting, thinking all the time, on what pills he should be taken together with the heroin to be more intoxicated. Another told, that he spent so much time on coming to the clinic and just sitting around doing nothing that he could just as well have spent the time on raising the money and getting the drugs himself, it did not really make a difference for him. Others told they were taking a nap instead of sitting being bored.

Other clients are however expressing more satisfaction. When they have taken their injection they become happy, relaxed. They tell it is very nice to be able to come here and take it – it gives a sense of security to know that they have the drugs here.

Where some clients talk about the boring aspect of sitting for hours in a treatment institution, others are telling that they think it is nice, that they have more time to talk with staff. One told, that she thought – for now at least – that it was exciting to be part of this new programme. She did however also expect the excitement to disappear with time, and then she would probably be back on the street, she thought.

A few clients have work or more demanding obligations during the day, as they do voluntary work or are activated as part of the municipalities attempt to re-socialize them. For these clients the first period of time with heroin has focused on how to make the everyday work with a more demanding treatment regime than what they have been used to. Some decide to only show up once a day, but do then complain about not really experiencing the full effect of the heroin.

Several clients talk about that they would have preferred longer opening hours so that they more independently could have decided when to appear, or so that they could become entirely free of the methadone.

When I have talked with some of the clients about why not more people have become enrolled in the programme they talk about that a lot of people are worried about to let go of their existing treatment arrangement. 'You know what you got – you do not know what you will have.' They tell that it is very difficult for them to tell staff or doctors at the facility where they have been until now, that they have been cheating with the methadone, and they are worried that having admitted that they will not be able to come back the same way, if they do not like the heroin clinic or treatment. Most of the clients enrolled in the programme have a long history of injecting drugs iv, and many of them have difficulties in continuing this habit. Many of them experience some kind of frustration in relation to the injection. There is no doubt about that many of them had dreamt of the problemfree hook, when first being enrolled in the programme. However some of them also tell that they are much more relaxed in relation to the injection, as the drug in the clinic is so clean that they can take it intra muscular if everything else fails.

Several clients tell that they think that staff worries too much about them and their drug intake. Clients become very frustrated when restriction is put on the dose or when they cannot have their drug because they appear intoxicated before the injection. They tell that they to a large extent have been able until now to decide and judge themselves, and they think it is too much when somebody else is taken over the control. They tell that they know what they are doing, that they are used to manipulate with the drugs and the doses etc. and now, other people are taking over this responsibility – with possible sanctions as a result.

Finally some clients tell that their biggest reason for choosing the heroin is that they are tired of the methadone, they want to get the methadone out of their bodies. They think it will be easier to get out of the heroin, than they have experienced with the methadone. They do also themselves tell that that is one of the reasons for them staying in the programme even though they did not have the effect of the heroin that they had hoped for.