LESSONS FOR DRUG POLICY SERIES

Globally Informed, Locally Responsive

Hong Kong's Common-Sense Approach to Expanding Methadone Treatment

OPEN SOCIETY FOUNDATIONS

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Robert G. Newman, MD

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Foreword

Methadone, a medicine prescribed and taken daily to reduce craving for and use of heroin and a host of opioid pain medications, is often referred to as the best-studied and most effective treatment for drug dependence. There indeed have been a host of studies over the course of more than 50 years, reported from around the world, that have quantified the medicine's effects on individual patients and on the community as a whole: documented decreased use of illicit opioids, improved family function, decreased crime rates and increased employment, improved life satisfaction, and better adherence to other medical regimens. Far fewer are studies that report in any detail on the systems designed to deliver the medicine, and the conditions for their creation, expansion, and therapeutic success. As this report shows, these accounts can be as important, and tell us as much about addiction treatment and its potential for serving those who want and need care and the communities in which they live, as any assessment of methadone's effects on individual recipients.

Comparative assessment of methadone's potential for serving patients and enhancing the wellbeing of the community as a whole is particularly critical to tease out what can be attributed to medicine, and what to the design of the treatment system. The distinction is between efficacy and effectiveness. The former term refers to the impact to be expected from a medical treatment under ideal circumstances; the latter describes the likely impact when treatment is delivered under real-life conditions. To illustrate, a medication can be enormously effective when studied in a controlled research environment, with carefully screened and fully compliant "subjects," but be dismissed—appropriately—as irrelevant if for whatever reason(s) it is unacceptable to patients, if local communities refuse to permit treatment to be offered in their midst, or if professional and/or political authorities make unreasonable demands on the providers and patients.

The Global Drug Policy Program of the Open Society Foundations asked Robert G. Newman, MD, a pioneer in establishing and expanding methadone treatment in New York City and a technical advisor to Hong Kong in that city's determined efforts to expand heroin addiction treatment in the mid-1970s, to reflect on Hong Kong's experience. This report is more than an overview of how Hong Kong proceeded and its success in treating heroin dependence and controlling HIV; it also presents what Dr. Newman believes to be the political lessons for how localities can study experiences elsewhere and must adapt those experiences in light of local needs, resource availability, political realities, and expectations.

A priority of the approach in Hong Kong was to ignore restrictions and premises that inevitably would limit access and detract from achieving common-sense objectives such as retaining patients. Prompt admission processing was given very highest priority, and every possible effort was made to keep patients in treatment, even if they did not—at least initially—respond optimally. Policies such as those calling for "termination" of patients who do not respond as quickly and as optimally as the providers hope, although commonplace in most addiction treatment programs around the world, were rejected. To the layperson, it may seem obvious that treatment providers must do everything possible to retain patients in treatment—perhaps especially patients who have not responded optimally. To those familiar with how often concern over illicit drug control defies common sense, however, Hong Kong's simple steps to ensure continuity of treatment are refreshing.

Hong Kong also increased access to methadone treatment by avoiding over-medicalization, and refusing to allow "the best" to become the enemy of "the good." Staffing patterns have reflected practical considerations regarding who might be available to provide what type(s) or care. Thus, in contrast to many countries, methadone in Hong Kong is dispensed almost exclusively by trained paraprofessionals, rather than by physicians, nurses, or pharmacists. Medical oversight is a part of the system, but so is a commitment to make treatment available with optimal convenience for patients. Late evening as well as early morning dispensing hours are available at selected sites, and a patient originally enrolled in any one of the city's 20 clinics can receive medication in any of the other facilities with no prior arrangements. This is akin to the customer service provided worldwide by many banks, where clients can obtain service from any teller window in any branch.

As Dr. Newman notes, this is pragmatism in action. It is also an approach that has continued to work for decades to control heroin dependence and its negative consequences, such as HIV infection and crime, which have been common among people who inject heroin across East and Southeast Asia.

Reading this study, several lessons seem clearest. First is the importance of locality. As Dr. Newman notes, and Hong Kong officials understood from the outset, international best practices and norms are instructive but insufficient. Hong Kong studied examples from

other cities, including New York, where Dr. Newman himself had done much to shape the delivery system. But Hong Kong recognized that the need to accept and adapt to local realities was absolutely critical. Nor has the city spent much time promoting its innovations or successes to the international community. This is an important reminder, especially relevant for drug and HIV programming everywhere, of the possibilities when one surveys globally but acts locally, and of the importance prioritizing action over publicizing.

Second, Hong Kong took greatly expanded access to treatment as its starting point, and did not lose that focus. As Dr. Newman notes, this clarity and unbending commitment was the critical element in developing innovations. This is not to say that Hong Kong has fully achieved its ideal, or that its methadone program has no room for improvement. Rather, as with the Brazilian commitment to deliver antiretroviral treatment to all citizens with HIV, treatment for all was the aspiration that, from the start of programming in the 1970s, shaped conceptions of what was possible—and imperative. Rather than waiting for research, Hong Kong conducted research and scaled up at the same time. Rather than starting from the need to control patients who needed treatment and doctors who dispensed it, Hong Kong prioritized making treatment widely available and expediting enrollment.

Finally, Hong Kong authorities accepted from the very outset the reality underscored by many researchers, but rejected by the majority of clinicians and politicians in countries throughout the world: that opiate addiction is a chronic, notoriously relapsing condition that defies "cure." When such acceptance is lacking, treatment efforts will inevitably be deemed failures. This is an intentionally brief study and volumes could be written. The basic lesson of these pages, however, goes beyond methadone maintenance treatment. Rather, the Hong Kong experience is a reminder of the most basic and important exercise in priority setting, particularly in the field of health services for those who use illicit drugs: the need to make systems responsive to the needs of patients, rather than the other way around.

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No one, however, deserves more appreciation or more credit for the achievements in Hong Kong than the late Peter E. I. Lee, Narcotics Commissioner from 1975 to 1982. It was Mr. Lee's wisdom, conviction, and consistent support and advocacy without which the accomplishments described in this report would not have been possible.

Executive Summary

Drug policies in China were shaped over the centuries by foreign and domestic forces, including the two Opium Wars of the 1800s that resulted in the *de facto* legalization of opium across the country. In Hong Kong, an opium market controlled by a government monopoly was an important part of the territory's legal revenue until 1947, when the British colonial government, in a dramatic about-face, implemented a strict opium prohibition policy. The eventual result of this change was that many opium smokers in Hong Kong turned to cheaper and more readily available heroin and, over time, to using by injection. In the two decades following the introduction of opium prohibition, there was virtually no readily available addiction treatment in Hong Kong. In the early 1960s, local medical authorities introduced a short-lived, half-hearted, in-patient detoxification service utilizing methadone to relieve craving for and reduce injection of heroin. Disappointing results and high cost led the effort to be discontinued in 1965, and for the next ten years treatment of addiction in Hong Kong was limited primarily to two abstinence-based programs. One was compulsory, operated by the Prisons Department for drug dependent inmates, and the other was a voluntary, residential, non-governmental (but heavily subsidized) program operated by the Society for the Aid and Rehabilitation of Drug Abusers (SARDA). Both of these initiatives continue almost unchanged to the present day.

In the mid-1970s, however, the Hong Kong government decided it was imperative to develop addiction treatment services on a scale sufficient to offer all opiate-dependent persons the prompt access to care that many wanted and needed. It was determined that an ambulatory program relying primarily on longer-term, easily accessible, and affordable methadone treatment could possibly achieve this ambitious objective, and in a remarkably

short period of time it was achieved. The openness of the authorities to learning from others, a critical feature of this history, led to a round-the-world study tour. The visit to New York, in particular, influenced the conclusion that rapid scale-up of methadone maintenance treatment was possible.

What has emerged over the past four decades as The Hong Kong Model has helped countless opiate-dependent people access treatment. Begun before awareness of HIV, the program has also contributed greatly to successful control of HIV infection in Hong Kong, avoiding the HIV/AIDS epidemic among people who inject drugs that has been experienced in most other countries of East and Southeast Asia. This double success—effective treatment for opioid addiction and effective prevention of HIV—was primarily a consequence of the following features of Hong Kong's methadone program:

- There are very few barriers to entry into methadone treatment; same-day admission and readmission to the ambulatory clinics are the rule and not the exception. The program does not require a referral or appointment and only requests completion of a simple form, a small fee, and a brief medical examination.
- A mix of trained volunteers, medical professionals, and a very limited number of social workers permits the operation of multiple clinics at low cost and effective scale. The Hong Kong authorities resisted the consensus among addiction professionals elsewhere that methadone maintenance requires a preponderance of specially trained medical, social, and psychological professionals.
- Accessible hours, from early in the morning until late in the evening, reduce the barriers for people seeking daily treatment. These hours are maintained even during city-wide emergencies.
- Patients are not pressured to be "weaned off" methadone, as is the case in many treatment programs around the world.
- While participants are asked to have regular urine testing to monitor progress, the tests have been entirely voluntary from the outset.

The Hong Kong methadone treatment approach—as in every country—has limits. However, in developing an independent model specific to the local context, rather than follow an international template, Hong Kong's senior officials have demonstrated extraordinary commitment. For their part, the decision-makers who were charged with fulfilling that commitment showed both the willingness to emulate and to innovate, but—at least as important—the courage to reject advice that, whatever its academic appeal and demonstrated efficacy elsewhere, seemed inapplicable in the local environment.

1. Background

1. History

Domestically produced opium had been available in China for centuries, but it was not until the mid-late 1800s that opium use was deemed problematic. At that time, there was high demand for Chinese tea in Europe, for which traders were eager to pay with relatively inexpensive opium (mainly from India) rather than with silver. Inevitably, an increase in the supply of opium and an associated decrease in cost led to progressively more demand. Concurrently, there was a rise in "narcophobia" in which opium became a scapegoat blamed for a broad range of social and cultural problems.

Allegedly spurred on in part by the death of his own son from an opiate overdose, Daoguang, the sixth Qing emperor to rule over China, decided to put an end to the opium trade.[1] When diplomacy failed, the result was the first Opium War from 1839 to 1842, which ended in a disastrous defeat for China. The Treaty of Nanking ending that war required that several ports (including Canton, about 100 miles from Hong Kong) be opened to European traders, that Hong Kong be ceded to the British, and that $20 million in "compensation" be paid by China. The opium trade henceforth was not only permitted, but encouraged. Some 15 years later, China tried once more to prevent the importation and sale of opium, but this second Opium War, from 1856 to 1858, also ended in defeat. The Treaty of Tientsin formally mandated the legalization of the opium trade in China.[2]

Shortly after the end of the Second World War, Britain became an advocate for opium prohibition. In 1946, the British Colonial government, partly in response to pressure

from the United States, demanded that Hong Kong institute a policy of strict prohibition of the sale and use of opium. In subsequent years, the overwhelming focus of anti-drug efforts in Hong Kong—as almost everywhere else—was on curtailing supply of and access to drugs. Inevitably, those efforts proved futile. To the relatively modest extent that supply-reduction measures succeeded in making drugs more difficult to obtain (at least in the short term), they generally also resulted in dramatic increases in drug prices. The demand for drugs among people dependent on them is relatively inelastic, and a shortage of supply often leads to a switch to a cheaper, more readily accessible alternative opiate, and/or to a more effective (but in the case of injecting, also potentially far more lethal) means of administration.

Precisely this scenario played out in Hong Kong. Once opium could no longer be obtained legally, many drug users turned to smoking heroin (a practice popularly known as "chasing the dragon" and "firing the ack-ack gun"), and ultimately to heroin by intravenous injection. By the early 1960s it was estimated that 60–70 percent of the colony's drug-dependent persons were heroin users, a proportion that was said to have increased to 80 to 90 percent by 1971.[3] Very little was done by Hong Kong authorities to provide treatment for heroin dependence during the first 15 years following the introduction of prohibition. Instead, the key focus was on stressing to the public the terrible consequences of addiction. The view propagated by government was that once in the grip of drugs the user becomes a slave, and death is the only release.[4] While the stereotype of the craven dependent drug user and the inevitability of a fatal outcome are false, in the absence of treatment, death indeed is all-too-often the outcome.

Across the border in Mainland China, the political and administrative environment became very different with the founding of the People's Republic of China under the leadership of the Communist Party. In 1949, it was estimated that some 4.4 percent of the country's population were heroin users.[5] With the launch of a country-wide prohibition campaign, drug addiction was off the radar after three years. That early success, however, could not be maintained. Thus, in 2015 it was reported, "Heroin is now the primary drug of concern in China ... China [is] predicted to have the most heroin users of any country in the world within 5 years."[6] Furthermore, the World Health Organization (WHO), in 2008, determined that "most of the unmet need for treatment [of opiate dependence] is in Asia ... particularly in China."[7]

2. Addiction as a Chronic Medical Condition

Developments in the science of addiction that would eventually influence Hong Kong had been taking place decades earlier on the other side of the world. In 1920, a New York internist, Dr. Ernest Bishop, wrote in the *American Journal of Public Health* that, "narcotic addiction is a disease; the laws make it a crime."[8] To underscore the revolutionary nature of this pronouncement at the time, it came just one year after the New York City Health Commissioner had stated that drug addiction was, "born in the underworld and is the twin brother of every crime in the great category of violence."[9] Dr. Bishop's view was echoed only six years later in Britain, where the Rolleston Commission (an expert group established by the UK Home Office) concluded, "Addiction to morphine and heroin must be regarded as a manifestation of a morbid state, and not as a form of vicious indulgence."[10] And almost 40 years after Rolleston, a Canadian physician, Robert Halliday, declared (quite prematurely, it must be said), "It is now widely accepted that the addict is a sick person ... and as such requires medical and other treatment."[11]

In the almost 100 years since Dr. Bishop's observation, the consistent experience around the world has been that responding to addiction first and foremost as a crime is futile at best, and at worst can aggravate greatly the problem for drug users and society. Severe sanctions, whether imposed on suppliers, users or both, simply have not worked. And yet, a predominantly criminal response continues to be pursued by policy-makers in many countries.

On the other hand, we now know that the *disease* of addiction—like most chronic medical conditions—cannot be cured but *can be treated*, and treated with very considerable effectiveness. However, even among those who claim to embrace the premise that addiction is a disease, there clearly is a great deal of ambivalence. An example is the Drug Court system in America and in a host of other countries. The rationale of almost all so-called treatment-in-lieu-of-incarceration programs, including drug courts, is that those addicted to drugs can benefit from treatment far more than from punishment. Such programs, however, in reality are based on the dual premise that problematic drug users are *both bad and sick*;[12] when the "sickness" does not respond to treatment as desired/demanded, the "patient" generally pays the price by being incarcerated. For example, in Singapore, "the approach is to try hard to wean [addicts] off drugs and deter them from relapsing. They are given two chances in a drug rehabilitation centre ... Those who are still addicted go to prison."[13]

The truth is that even if one accepted addiction as primarily a medical condition, this meant little as long as there was nothing to do about it. That changed when Drs. Marie Nyswander and Vincent Dole, in the mid-1960s, first provided a basis for believing this sickness could be treated effectively with medication. In 1965, they published the very positive

response of 22 long-term problematic heroin users who were maintained on methadone while cared for in the research unit of the Rockefeller Institute (later renamed the Rockefeller University) in New York City.[14] Shortly thereafter they replicated their favorable observations with 750 patients treated with methadone maintenance in a non-research setting.[15] By the late 1960s, there emerged what would become an enormous body of published empirical evidence confirming the sustained effectiveness of methadone maintenance to treat opiate addiction, and within little more than a decade, many tens of thousands of patients were receiving this treatment around the world.

Sham Shui Po Chinese Public Dispensary, Hong Kong

Source: http://www.docomomo.hk/wp-content/uploads/2013/03/DSC05092.jpg

II. Methadone's Use Prior to 1975

In Hong Kong in the 1950s, there was limited use of meprobamate (a non-opiate anxiolytic medication) to relieve opiate withdrawal symptoms.[16] But methadone, a much more effective medication in the treatment of opiate dependence, was coming onto the scene. In Hong Kong, as in many other places, methadone had been used for short-term detoxification of individuals with opiate dependence for years before the concept and practice of "maintenance" were introduced by Drs. Nyswander and Dole. Starting in 1961, the Hong Kong government's Department of Medical and Health Services (DMHS) used methadone in an experimental inpatient detoxification treatment service. A total of 840 patients were enrolled before that program was closed in 1965. Thereafter DMHS withdrew from the field of treatment for addiction and effectively banned all forms of ambulatory care.[17] At the time, the future looked bleak; DMHS had gained experience in the voluntary treatment of addiction, but decided against putting it into wider practice.[18]

The use of methadone employed in an ambulatory setting was considered briefly in 1965. A "working party" was appointed by the government to advise whether out-patient treatment with methadone had merit, and its conclusion, reached unanimously, was clear, "[M]ethadone substitution treatment could not be effective when the patient was at liberty, in an environment where heroin was available."[19] Despite this unqualified rejection of methadone maintenance provided on an ambulatory basis, within less than a decade the government established what would soon be one of the largest methadone programs in the world.

Until the early 1970s, addiction treatment in Hong Kong was essentially limited to two programs. The first was a program for addicted inmates operated by and within the

Correctional Department, and the other a voluntary non-governmental program established by SARDA in 1961. From its inception, SARDA, though a non-governmental organization (NGO), has been almost entirely underwritten by the government; its residential component is located on a small island, roughly a one-hour boat ride from Hong Kong. Neither the Corrections Department nor the SARDA program utilized methadone, and neither could be expanded to any significant extent.

Around 1969, Dr. Lik Kiu Ding insisted that methadone maintenance could play a positive role in addressing the opiate dependence problem in Hong Kong.[20] Born in 1921 to an impoverished family in British Malaya, Dr. Ding earned a medical degree from Johns Hopkins University, but throughout his life he was first and foremost a social activist. Dr. Ding was impressed by the initial studies of Nyswander and Dole, which he reportedly found to be convincing on social, medical, economic, and moral grounds.* Initially, resistance to the proposed introduction of methadone maintenance in Hong Kong remained firm. In light of the almost universal abhorrence of government providing an opioid to those dependent on heroin, Dr. Ding tempered his enthusiasm and focused on seeking support for no more than a small research study. With government approval, the Discharged Prisoners' Aid Society (DPAS, renamed in 1985 the Society of Rehabilitation and Crime Prevention), an NGO with substantial government subvention, agreed in 1972 to carry out a placebo-controlled, double-blind trial of methadone treatment. At the same time, the DMHS decided to initiate its own "pilot" program with one clinic to provide methadone to a maximum of 500 patients.

The DPAS trial involved 100 long-term heroin users who were hospitalized for two weeks and stabilized as in-patients on 60 mg of methadone per day. Just before discharge from the hospital, they were assigned randomly to one of two groups. For the experimental group, methadone was continued and the dose adjusted according to patients' reports and clinicians' observations (maximum daily dose was 130 mg, and mean dose was 97 mg). The control group was detoxified by a dose reduction of 1 mg each day, and thereafter given only placebo.

The results of the DPAS study were quite dramatic. There were no dropouts from either the experimental or the control group during the first weeks after discharge from hospital, but by the time the diminishing dose of methadone given to the control subjects was down to 30 mg per day, only 5 individuals were still attending the clinic compared to 38 of those in the maintenance cohort—10 percent versus 76 percent. When the three-year study ended, only 1 (2 percent) of the 50 placebo subjects was still in treatment, compared

* Nyswander and Dole's published reports were reinforced for Dr. Ding by an acquaintance, Dr. Paul Torrens, an American physician who had recently joined the Hong Kong Maryknoll Hospital as its chief executive. Dr. Torrens shared with Dr. Ding his favorable first-hand experiences over the course of several years as medical director of one of the methadone clinics operated by Beth Israel Hospital in New York.

to 28 (56 percent) of the 50 assigned to methadone maintenance. The latter retention rate compares favorably with the best results—in the 1970s and to this day—of *any* addiction treatment program in the world. As for criminal convictions, the controls were convicted of twice as many crimes during the three-year trial than the treatment subjects (averages of 3.17 and 1.41, respectively).[21]

Elsewhere in the world, despite the clear benefits of methadone maintenance evident in carefully designed clinical trials, many who considered it to be lacking in "scientific evidence" dismissed the treatment.[22] For example, a double-blind study carried out in Sweden in the late 1970s provided compelling evidence of the effectiveness of methadone compared to that of placebo, but the published report ended with the following comment; "In spite of the present results there is a politically inspired highly emotional resistance towards the Swedish MMT program."[23]

In Hong Kong, the situation was different. The results of the placebo-controlled trial carried out by DPAS were not rejected or ignored; authorities simply did not wait for them to justify major expansion of addiction treatment capacity. Indeed, the study was not completed until the end of 1975, and results would not be published until several years after that.[24, 25] However, by 1972, the year the DPAS trial began, the first "pilot" clinic operated by DMHS was initiated, and two years later three more DMHS facilities providing methadone maintenance were opened.

III. A Radical Shift Toward a Commitment to Treatment

1. Initiation of Changes

The shift toward Hong Kong's commitment to treatment was catalyzed, in large part, by the recognition that the old approaches of prohibition and residential, inpatient treatment for a limited number were simply insufficient. Toward the end of 1973, Hong Kong authorities could not ignore the fact that they were facing a major health and social crisis associated with a growing number of opiate-dependent, heroin-injecting residents, a crisis that had proven impervious both to law enforcement measures and to the limited treatment services launched to date. They determined that while efforts should continue to curtail heroin trafficking and supply, it was imperative to reduce substantially the demand for and use of the drug. The sense of urgency was heightened considerably when a major commitment to fight government corruption (including, particularly, in the Police Department) was heralded by the establishment, in 1974, of the Independent Commission Against Corruption (ICAC).[26] It was anticipated that this campaign would substantially limit the supply and increase the cost of heroin, provoking a crisis for those dependent on it. Without additional intervention, the result would be an increase in crime, illness, and death. And indeed, the ICAC quickly achieved the hoped-for success in interdiction: between 1976 and 1978, "ICAC shut down a heroin racket at the Ya Mau Tei fruit market ... where police had received kickbacks from

drug dealers. Some 87 police officers were arrested ... [and] the local police station was left nearly empty."[27]

The government concluded that treatment must be offered to all those dependent on opioids who were willing to accept it. The objective was two-fold: to address a crisis that threatened a very large and growing opioid-dependent population, as well as to serve the interests of the community concerned about public health and safety. Clearly, the response could not simply be to continue the existing approach.

Three of the most senior and highly respected medical authorities in Hong Kong were assigned by the Action Committee Against Narcotics (ACAN)**, [28] the task of undertaking a world-wide assessment of anti-narcotics treatment efforts and to recommend which one(s) might have the best likelihood of making a major impact in Hong Kong. The team was composed of Gerald Choa, MD, the Director of DMHS, who later became the founding Dean of the Faculty of Medicine of the Chinese University of Hong Kong; T. M. Teoh, MD, a senior clinician with many years of experience working with DMHS; and Sir Alberto Rodriguez, an extraordinarily well-respected and highly decorated medical doctor, academician, and politician knighted by Queen Elizabeth in 1971, who was designated the Chairman of ACAN in 1973. Clearly, ACAN believed that whatever recommendations were to be made should come from professionals who enjoyed the highest possible degree of respect and credibility.

The three travelled to the United States and Europe to examine treatment responses. Upon their return to Hong Kong, they recommended that universal access to treatment could only be achieved, if at all, through reliance on methadone, with a program patterned after the one in New York City. Only in New York City had they observed treatment capability that was achieved very quickly and on the major scale needed in Hong Kong, with compelling data demonstrating the ability to attract a very large population on a strictly voluntary basis,[29] with a high level of patient retention, and evidence of therapeutic effectiveness.[30] A 1973 assessment by the *New York Times'* editorial board, under the headline, "A Drug Success," summed up what had been achieved, "The city's own methadone treatment program . . . has so swiftly and so successfully expanded its capabilities that there no longer are waiting lists for admission into methadone treatment."[31]

** ACAN was organized in 1973 as, "the sole source of advice to the Government on all aspects of its anti-narcotics problem."

2. Acceptance of the Goal of Methadone Treatment on Demand—but on Hong Kong's Terms

Dr. Choa prefaced his team's support of medication-based treatment of dependence by noting what was believed to be a marked difference in the nature of drug users in Hong Kong compared to other countries. He observed that drug addiction had long been regarded as a psychological problem in most Western countries, and that, "[i]n those societies addicts are labeled as social misfits or outcasts or inadequate or irresponsible persons, showing such abnormal traits as emotional immaturity, character disorder, personality defect or criminal tendency."[32] While this is hardly an applicable generalization regarding drug users anywhere, Dr. Choa presented a very different picture of addicts in Hong Kong, describing them as having an average age of almost 38 years, and over 90 percent being employed. In Dr. Choa's words, "[T]here are no stigma to distinguish them from the rest of society."[33] Dr. Choa also stressed that international experts agreed that success in confronting addiction rested on making treatment available to all who wished to have it, and keeping treatment programs open so people could continue treatment as needed.

Paradoxically, however, Dr. Choa qualified his endorsement of methadone treatment in Hong Kong by stating that to augment the medication, social workers should be "required to give counseling to the addicts."[34] This qualification represented a clear contradiction, endorsing establishment of widespread availability of treatment on the one hand, but simultaneously stating that this treatment *requires* social workers to provide counseling in a community where there was a great shortage of trained social workers. Had Dr. Choa's stated prerequisite been accepted, it would have been the death-knell for efforts to make expansion of treatment in Hong Kong possible, even on a very limited scale.

In mid-1974, ACAN accepted the fundamental recommendation to rapidly expand existing methadone treatment capacity, and it assigned DMHS with the responsibility to achieve this goal. DMHS recruited a consultant, Robert G. Newman, MD (the author of this report), who had established and directed the New York City Department of Health methadone program, to develop the Hong Kong program. The WHO's Drug Dependence Unit provided financial support with guidance to prepare "recommendations regarding an effective and efficient policy and executive structure to control Hong Kong's treatment and rehabilitation programmes and their development."[35]

The consultant's final report to DMHS (hereafter, "the Report") recommended how Hong Kong should proceed.[36] Perhaps most significantly, the Report urged Government "to develop a *detoxification* program with a substantial capacity to provide a short-term withdrawal treatment on an out-patient basis ... *[but] to curtail markedly methadone maintenance treatment until adequate financial and personnel resources are available.*" (emphasis added).[37]

In retrospect, the explanation (or perhaps, the rationalization) was that at the time there was a severe shortage of all key professionals in Hong Kong due to a major economic crisis. The Report concluded that obstacles to "adequate" staffing for effective, ongoing, maintenance, as defined (legally and programmatically) elsewhere probably could not be overcome.[38]

And yet, the premise that adequate staffing, however defined, was a *sine qua non* for methadone maintenance treatment was the antithesis of the guiding principle that just five years earlier had been accepted and pursued, vigorously and successfully, in New York City. New York proceeded from the assumption that any requirement that would severely limit the number of patients who could be accommodated was unacceptable. It should be noted that the belief, almost universal to this day, that some specified minimum staffing pattern is required for effective treatment of addiction has never been supported by credible evidence.

Both in New York City, and subsequently in Hong Kong, a litany of reasons were presented to support the admonition that one must "go slow" in establishing and expanding methadone treatment facilities: rapid expansion of methadone treatment could be a widely publicized disaster that would undermine treatment efforts everywhere for many years to come; individualization of care and "comprehensive psychosocial services" were seen as *indispensable* components of treatment and required extensive time for recruitment and training of staff; each new clinic had to build up its patient population slowly to avoid overloading a staff comprised of neophytes; etc. The concept of rapid, large-scale expansion of addiction treatment services of any kind was almost universally rejected.

In New York City, the consistent response of the Department of Health (NYC DoH) leadership to warnings of critics within and outside city government was to pose the rhetorical question, "How convincing will these concerns and the admonition to proceed slowly be to parents whose children sought help but were turned away and placed on 'waiting lists,' and subsequently died of an overdose?" The answer was clear, and the NYC DoH prevailed; within two years some 12,000 patients had been admitted and over 10,000 were in active treatment.[39] Precisely the same philosophy was embraced just a few years later by DMHS in Hong Kong, and nowhere else was the fundamental commitment to "treatment on demand" embraced with greater zeal, determination, and success. Like their counterparts in New York City a few years earlier, Hong Kong authorities concluded that nothing could justify abandoning those who wanted and needed help in dealing with their addiction.

Nevertheless, the initial response to the recommendations submitted to the Hong Kong DMHS was discouraging; the Report was tabled, apparently without further discussion, and no action was taken until Peter E. I. Lee became Commissioner for Narcotics later in 1975. Mr. Lee was a career civil servant of the British Government who had served many years in East Africa before joining the Hong Kong Administrative Services in 1961.[40] He had no prior experience related to addiction, but quickly concluded that, in the absence of any

other proposal to make treatment available promptly to all who were willing to accept it, the key recommendation of the Report should be implemented: namely, that a large-scale methadone program be established that at least initially would focus mainly on detoxification. Commissioner Lee sought and received the endorsement of the Governor of Hong Kong, who ensured that the DMHS committed to, and provided, total and unqualified support.[41]

IV. Pursuing the Goal of Making Methadone Treatment Accessible to All

Many of the recommendations in the Report to DMHS were subsequently accepted, including:

- accept women on an equal basis with men as both staff and patients (the original DMHS clinics excluded them from both categories);
- reject the notion of *compulsory* participation in methadone treatment under any circumstances;
- discontinue naloxone tests for screening applicants for admission who might not be dependent on opioids; and
- forgo *routine mandatory* urine testing for illicit drugs.

Particularly instructive, however, are those recommendations, including several that had been described as "imperative," that were *ignored* because they were considered to be a barrier to achieving large-scale, rapid expansion of treatment. A few key examples follow.

Treatment labels: It was recommended that a clear distinction be drawn between clinics offering *maintenance* with methadone, where the goal is indefinite retention in treatment,

and a separate group of facilities whose goal would be short-term (maximum 2-4 weeks) gradual *detoxification*. It was urged that each existing clinic, and each one to be established subsequently, offer *either* one or the other, but not both. As a first step, the recommendation was that two of the three recently established methadone clinics operated by the DMHS should provide detoxification only.[42]

Such a separation of maintenance and detoxification services was and continues to be common in many countries (for example, the United States[43]) and in some is enforced by regulation. The Hong Kong Government sought to follow this recommendation, but it was quickly determined that applicants for treatment refused to acknowledge the distinction. When asked whether they wished to be detoxified or "maintained" indefinitely, almost all dismissed the latter option out of hand. And once in treatment, even after several years, patients generally insisted they were there for detoxification and definitely not for indefinite-duration "maintenance." With typical pragmatism, the program deleted both terms, methadone maintenance and methadone detoxification, and for the past 40 years has simply used the label "methadone treatment."

Almost a quarter-century after the program was initiated, a survey of patients found that 55 percent reported detoxification as the reason they sought admission.[44] In practice, it quickly became clear that whatever their *stated* ultimate goal, very few Hong Kong patients actually opt to be detoxified at any point. A 1996 survey of active patients found that 50 percent had been in treatment for 15 years or longer.[45] A subsequent analysis by the Hong Kong Audit Commission found that in the years 2002–2007 no more than 3 percent of all program admissions had been identified as "detoxification patients," and of these only about one-third were judged to have been "successfully detoxified" (no follow-up data were presented).[46] It should be noted that there apparently has never been staff pressure (let alone, demand) to get patients to agree to be detoxified. By contrast, a national survey in the United States, published in 1992, found that 50 percent of methadone maintenance programs "encouraged" patients to detoxify within six months of admission.[47]

Staffing: The Report outlined a staffing pattern that was considerably looser than that which was mandated at the time by the authorities governing methadone maintenance in the United States. Specifically, for a methadone clinic with roughly 1,000 patients the Report called for 1.5 full-time-equivalent physicians, 10 nurses, a social worker, 10 "welfare assistants" and four "clerical assistants."[48]

These recommendations could not have been expressed more strongly. The positions listed above were said to be the bare minimum required to operate a methadone clinic. If the resources were not available, then abandoning methadone maintenance was considered to be the best option. Interestingly, this unqualified pronouncement reflected concerns that

were identical to those expressed forcefully to the NYC DoH just five years earlier, and that had been rejected out of hand by the Health Department's leadership, including the author of the Report. In both cases it was feared that creating a large-scale treatment program without what were deemed to be the minimal required resources would result in a highly publicized failure and discredit the government's effort as well as methadone treatment itself. It is also worth noting that both in New York City and in Hong Kong the emphatic admonition to "go slow" came primarily from the *advocates* of methadone treatment, and not from its opponents.

Fortunately, neither Hong Kong nor New York City, a few years earlier, heeded the dire warnings. The rationale in the two cities was identical: if caution entailed abandonment of those needing help, it had to be disregarded; there simply was no alternative way to make treatment for all a reality.

For several decades, almost exclusively, members of the Auxiliary Medical Service (AMS) staffed the clinics operated by DMHS.[49] These are volunteers with a range of backgrounds receiving a modest hourly honorarium for their work. In 2013, there were approximately 400 AMS volunteers staffing about 150 positions in methadone clinics that generally served a combined total of 6,000–8,000 patients per day, but on occasion substantially more.[50] From the outset they have been responsible for patient registration, dispensing of methadone, and in several clinics collection of patient fees as well.

In 2013, there were also three full-time and approximately 30 part-time physicians assigned to the program's 20 clinics. Physicians have never been required to have any specific qualifications or training, and nurses have never played a role of any kind. Some patients who were believed to require social service support initially were directed to the nearest social service providers in the community. In 1993, however, some 17 years after the original program expansion, resources in Hong Kong became sufficient to permit a limited number of social service staff to be assigned to the clinics by SARDA. Although from its inception SARDA has been, and remains, the major provider of voluntary, residential, abstinence-based addiction treatment, there appear to have been no conflicts between the orientation of SARDA and that of the methadone program, and counseling or other forms of psychosocial services have never been mandated. The Department of Health (successor of DMHS after the separate formation of the Hospital Authority as a statutory body) welcomed social workers from SARDA when they became available, and SARDA was happy to provide them. While a distinction between "maintenance" and "treatment" exists in the minds of many, in Hong Kong, as in the rest of the world, such a distinction has never received much attention either before or after SARDA social services were made available in methadone treatment clinics. The program has been called the Methadone Treatment Programme almost from the outset, and as far as the author knows no one has ever challenged

the assumption that provision of methadone in Hong Kong, with or without "counseling," is treatment.

The preoccupation with what is deemed "adequate" staffing (however defined) continues to be widespread throughout the world. For example, a 2015 publication of guidelines of the leading addiction medicine professional association in the United States, the American Society of Addiction Medicine (ASAM), proclaimed, "*At a minimum,* psychosocial treatment [in conjunction with medication] for the treatment of opioid use disorder should include the following: psychosocial needs assessment, supportive counseling, links to existing family support, and referrals to community services" [emphasis added].[51] In this respect, and in its failure to consider and to address the consequences when this "minimum" is not available, ASAM reflects views and attitudes expressed by virtually all addiction treatment providers to the present day, notwithstanding the absence of supportive evidence.

V. Other Observations Regarding Hong Kong's Approach to Addiction Treatment

1. Treatment Under Governmental Auspices and Control

It is always possible that providers will utilize medical treatment—especially treatment that can make the difference between life and death—as a cudgel to demand that patients comply with various political and/or social norms. The possibility of such use of "therapeutic power" was noted by the author almost 50 years ago as follows, "It is entirely conceivable . . . that applicants might some day be rejected, or patients discharged, on the basis of political and/or anti-social behavior ('antisocial,' of course, is an arbitrary term to be defined by those in power)."[52] This concern might seem especially warranted with respect to a locale such as Hong Kong, where the government is the *only* provider of methadone treatment and by far the largest funder of all addiction treatment services. By contrast, in Portugal 90 percent of projects offering treatment to problematic drug users are carried out by non-governmental organizations (NGOs) and NGOs were found, "to be better than state agencies at establish-

ing mutual trust between service providers and users."[53] And in the United States in 2011l, only 10 percent of all methadone programs were operated by governmental agencies.[54]

With regard to criteria for termination of treatment, there essentially are none. Certainly, the widespread practice (in the United States and elsewhere) to "terminate" patients who evidence the problem that is pathognomonic of the condition being treated—drug misuse—has never been a practice of Hong Kong's methadone program.

It is worth noting that there apparently have been no reports suggesting that any of the policies and practices of the Hong Kong methadone program, including a firm commitment to patient confidentiality, have been affected by the change in government when Hong Kong was returned from British control to China's in 1997, and its designation as a "Special Administrative Region." The practices and policies of the treatment services in Mainland China, however, are in several key respects different from those that prevail in Hong Kong. Average methadone doses are reportedly significantly lower than in Hong Kong, and retention of patients is a problem.[55] Also, although China launched a large-scale methadone program in 2004 that was serving over 184,000 people a decade later,[56] it has continued to operate "detention centers" that have been found by Human Rights Watch to be little different from prisons or forced labor camps. Nor is China alone in this respect: in 2012 it was reported that, "more than 350,000 people identified as drug users in China, Viet Nam, Cambodia, and LAO PDR were detained in the name of 'treatment' ... for periods of up to five years."[57] Hong Kong has done well to maintain the humane character of its approach toward addiction treatment in this regional context.

2. Admission, Readmission, and Attendance

In Hong Kong, there are virtually no barriers to same-day admission for methadone treatment. From the outset, neither a referral nor an appointment has been required; it has been standard practice for applicants to complete a one-page form, receive a brief medical examination, and promptly be given the first day's dose of methadone. These procedures apply to those seeking readmission as well as to applicants not seen before. The same-day re-enrollment of patients previously in treatment is in sharp contrast to practices in many countries where methadone programs erect various barriers to readmission, ostensibly to discourage people from leaving the program "prematurely." In essence, the Hong Kong approach has been to value—for patients and the community—a readily accessible alternative to illicit drug use one day at a time, and how many days have elapsed since the last clinic attendance, and/or the last dose of medication, is largely irrelevant. The *one-day-at-a-time* philosophy, of course, is the underpinning of 12-step groups around the world, such as

Alcoholics Anonymous.[58] It is quite widely accepted when applied to management of alcoholism, but is rarely endorsed by care providers, policy-makers, or the community at large in the field of opiate dependence.

The immediacy of admission and readmission plays an especially critical role when the demand for treatment rises abruptly. For example, "The buffer role of methadone treatment ... was demonstrated dramatically in the early months of 1984, when a shortage of heroin in Hong Kong resulted in a marked price increase. As a consequence, attendance jumped by well over 30 percent and reached an all-time high of 10,000 patient visits per day."[59] There are not many addiction treatment programs in the world—governmental or non-governmental, for-profit or non-profit, medication-based or drug-free—that promptly accommodate any and all applicants in the best of times, let alone in crisis situations.

The average daily attendance at various clinics is proportional to the size and location of the communities they serve. Thus, a clinic on the small island of Cheung Chau, a little over six miles from Hong Kong, provides treatment to no more than about 35 patients per day, while the facility in Sham Shui Po, an extremely congested and busy part of Kowloon, sees as many as 1,500 patients daily. Patients are considered "discharged" if they fail to appear for their medication for two consecutive weeks; there is essentially no other reason for "termination."

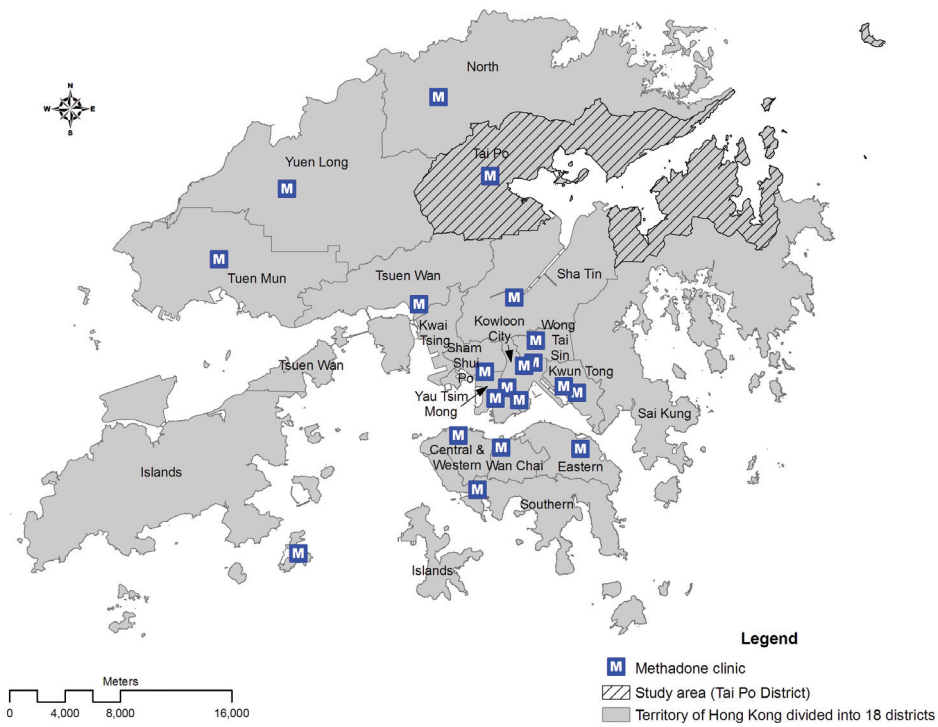
3. Take-Home Medication Policies

In the newspaper report of the opening of the first "experimental" DMHS methadone clinic in 1972, Dr. Choa was reported to say that he believed, "the daily attendance at the Centre need not be permanent. This means that depending on progress and the degree of confidence established, arrangements are possible at some future date that would permit patients to take a small supply home."[60] That "future date" has never come, and the question of take-home medication for patients of the program has apparently never been considered seriously.

The extensive geographic coverage of the program's facilities in Hong Kong lessens the burden for many to apply and remain in treatment. About 60 percent of methadone patients in Hong Kong live within less than one mile of a methadone clinic, and almost 85 percent spend no more than 15 minutes for traveling.[61] Furthermore, a major step toward lessening the burden of daily clinic visits was made in 2014, when the government implemented a system of up-to-the-minute, centrally-maintained computer records of all patients and their attendance and dosage histories. This has made it possible for patients, with no advance arrangements of any kind, to visit any of the 20 clinics in Hong Kong, present

their program ID card, and immediately receive the scheduled dose for that day. The system essentially functions like a bank: no bank would ever limit clients' access for transactions to a single specified branch—let alone to a particular teller's window.

FIGURE 1.
Map of Hong Kong showing boundaries of 18 administrative districts, location of 20 methadone clinics including the study clinic and the district where the clinic is located



Source: Wong N.S., Lee, S.S., and Lin H. (2009). Assessing the spatial distribution of methadone clinic clients and their access to treatment. *Harm Reduction Journal*, 2010; 7:14.

Of the twenty current clinics, five are open from 07:00 to 20:00, twelve are open evenings only from 18:00 to 22:00, and the remaining three have hours of operation that vary between seven and ten hours daily. Most clinics are open seven days a week.

The features cited above illustrate the efforts to minimize the inconvenience of daily attendance, and to implement policies and procedures consistent with that commitment. This level of sensitivity to the needs of methadone patients extends to emergency situations occasioned by natural disasters. For example, in 2011 Cyclone Nesat struck Hong Kong and an

advisory was sent to all radio and television stations asking them to broadcast the following, "The Department of Health announced that due to the tropical cyclone, all the department's clinics will be closed except for methadone clinics, which will provide normal service." [62]

4. A Fee for Treatment

In 1975, experts discussed charging all patients HK$1 for each day's attendance and medication administration (the equivalent would be less than U.S.$1 per week). The key argument against such a charge was that, while minimal, it might present a barrier to enrollment and attendance for some—perhaps less for fiscal reasons than for the fact that it could involve waiting in line to make payment to the "shroff" (cashier).

The rationale for initiating this nominal charge was that at the time all ambulatory health care services provided by the Hong Kong DMHS required the same payment of HK$1 per visit. If the sole exception had been methadone treatment, it could have raised concerns among potential applicants and patients regarding the government's motives. Notwithstanding this original thinking, during the past 40 years the price of government-sponsored ambulatory health care has increased to HK$63 (U.S.$8.20) per visit, but the HK$1 required for methadone patients has never been changed. The most recent estimate of the daily expenditure for heroin by individuals not in treatment appears to have been made almost 20 years ago, in 1998, when it was HK$254—approximately U.S.$33.[63]

The HK$1 daily per-visit fee has remained in place. To put this into perspective, approximately half of the methadone maintenance patients in the United States in 2008 reportedly paid out of pocket U.S.$13 or more daily,[64] in Australia patients pay, on average, at least AU$35 (U.S.$27) per week,[65] and in Mainland China patients are charged up to CNY10 (U.S.$1.2) per dose of methadone.[66] Although intermittent consideration has been given over the years to eliminating the charge for patients in Hong Kong, the general consensus is to keep a nominal fee since the model seems to be working.

5. Endorsement and Support of a Multi-Modality Treatment Approach

As has been true of almost every instance where methadone treatment has been added to the palette of services established for people using drugs, there initially was concern in Hong Kong that a massive new methadone treatment initiative would compromise the attractiveness, support, and viability of drug-free (non-medication-assisted) services. These

concerns have almost always been found to be unwarranted, and this certainly has been the case in Hong Kong. During 1975, the year the massive expansion of methadone treatment was just getting underway; there were 2,551 admissions to the SARDA drug-free residential program. Over the course of the subsequent three years, 1976 through 1978, admissions to the methadone program averaged 10,142 annually, while the number of admissions to SARDA remained essentially unchanged, with an annual average of 2,591.[67] And currently, some 40 years later, there have been essentially no changes in the status and the priority of the various programs providing addiction treatment.

While there are no available supporting data, it seems reasonable to speculate that the availability of immediate admission to medication-based ambulatory treatment might have been valuable in screening out applicants with little if any motivation to accept months of residential treatment on a relatively remote island, followed by an extended period of outpatient care with SARDA. Before methadone, however, there was essentially no alternative option for those voluntarily seeking relief. The methadone program made it possible for the first time to obtain help without separating oneself from family, jobs, etc.

The ambivalence of many who, in the early years before methadone treatment became an option, entered SARDA's residential program, but quite promptly regretted their decision is illustrated by the following widely-repeated anecdote from the mid-1970s. Patients who were determined to leave SARDA's island facility could do so, but were quite strongly discouraged—unless they had committed a serious infraction of the program's rules. Consequently, patients who wanted to be discharged would set their mattresses on fire, knowing that this would lead to prompt expulsion. Though no published reference to the practice exists, a "mattress deposit" was allegedly required of all new SARDA admissions, which would be forfeited if the mattress were set ablaze. Soon after the methadone program commenced the deposit requirement was discontinued.

6. A Narcotics Registry for Hong Kong

In addition to its primary focus on treatment, the Report also recommended that the Hong Kong Narcotics Registry, then completing its third year of operation but having yielded virtually no information of value, be either eliminated or radically changed. The government decided to pursue the latter course. In late 1975, the U.S. National Institute on Drug Abuse funded Mr. Bent Werbell, a computer expert who had designed the computerized New York City Narcotics Register, to develop and launch a new electronic system for gathering and analyzing drug data in Hong Kong.

The new Central Registry of Drug Abuse (CRDA), was launched in September 1976, and during the first 48 months received approximately 116,000 reports on 34,700 individuals.[68] It has continued since then to receive reports from, "a wide network of reporting agencies including law enforcement departments, treatment and welfare agencies, tertiary institutions, hospitals and clinics."[69]

A feature of particular public health value in the Hong Kong Registry has been the ability of any and all interested parties to access CRDA information and to individualize and download the data according to their own area(s) of focus.[70] Users of the database indicate the information they want and in what format: time period, number of reported drug users and other specifics (such as age, sex, and primary drug of abuse). No charge is involved for this access. From the outset, however, it was stressed that under no circumstances would any information be released that could identify individuals who had been reported. No instances have come to light in which this policy was breached, and it was re-stated in 2012, "The records of all persons reported to the CRDA are handled in strict confidence and are accessible only to those who are directly involved in the operation of the CRDA."[71]

VI. Assessing the Effectiveness the Hong Kong Methadone Program

While evaluation of the methadone treatment program in Hong Kong has not been a priority, the limited number of studies that do exist suggest that patients and public health experts are satisfied with the treatment and with the health and social outcomes with which it has been associated.

The Narcotics Division of the Hong Kong Security Bureau, a government agency independent from the DMHS, conducted a survey in 2000 of representatives and patients from the major addiction treatment programs in Hong Kong, members of governmental agencies, and academicians. It found a high degree of satisfaction on the part of patients, with over 90 percent satisfied with, "their degree of freedom, the facilities, staff attitude and waiting time." However, the same survey found that about 50 percent were dissatisfied with their dosage, and of these roughly 50 percent indicated they would prefer a lower dose, and 40 percent a higher dose.[72] As for the impact on the community, the survey concluded, "Due to the existence of the [methadone treatment] programme, the social costs of drug abuse in society in terms of loss of productivity as well as petty and property crimes have been reduced."[73] Its overall recommendation was that the methadone program should continue to comprise both maintenance and detoxification options, and to offer easy entry for all who wish to enroll.[74]

UNODC and UNAIDS also made a favorable assessment in 2009, noting that while 26 percent of the drug users entering the methadone program had prior criminal convictions, only 4 percent of patients were convicted of a crime after enrollment.[75] In particular, the report stressed the program's role in markedly curtailing the spread of HIV, "One of the most remarkable successes of the methadone programme in Hong Kong is that it has kept HIV prevalence at about 0.3 to 0.4 percent among participants."[76]

Dr. S.S. Lee, Professor of Infectious Diseases at the Chinese University of Hong Kong and, for almost 15 years, head of the Hong Kong government's AIDS Program, summarized the impact of the methadone program on containing the spread of HIV among drug users. Referring to the Hong Kong methadone program, Dr. Lee stated, "what started as a public security effort has quietly evolved to become a strategy for keeping drug users away from HIV."[77]

Of course, Hong Kong's impressive experience with respect to HIV/AIDS may well reflect a number of factors, but according to a team of epidemiologists, "the most plausible factor is the existence of a network of methadone clinics, which was already in place well before the local emergence of HIV."[78]

Impact on patient housing: A recent survey of housing arrangements of methadone patients found that among those in treatment for less than three months, 16 percent had no fixed address, compared to only 2 percent of those in treatment for six months or longer.[79] How this improvement was achieved, and the specific role of the methadone program, are not explained, but the figures would seem to speak for themselves.

View of the former Director-General of the WHO: Dr. Margaret Chan, Director-General of the WHO from 2007 to 2017 and Director of the Hong Kong Department of Health from 1994 to 2003, recently summed up her assessment of the Hong Kong methadone program as follows:

> I used to work in Hong Kong. We had one of the most robust, liberal harm reduction programmes: methadone replacement. After its implementation, petty crimes that addicts commit to feed their addiction were reduced. I speak from personal experience. I would encourage governments to consider such programmes. They are not easy, but they work.[80]

VII. Persistent Challenges and Opportunities

Dosages for methadone patients: From the outset of the expanded methadone program physicians in Hong Kong were reluctant to order relatively higher dosages—that is, methadone dosages known to be associated with most favorable outcomes. No rationale has been given, and while there has been a gradual increase in the average dosage, the problem persists. Thus, in 2015 a survey of almost 700 methadone patients revealed that for those aged 40 and below, slightly over 87 percent received less than 70 mg per day; patients in older subgroups received progressively higher average doses, but even among those over age 60 half were given less than 70 mg daily.[81]

It should be noted, firstly, that there is no published evidence to suggest younger opiate-dependent patients require lower doses of methadone for optimal results. The corollary is also true: there is nothing to support the notion that older patients require higher dosage. More importantly, it has long been known that for most patients at least 60 mg per day is most effective.[82] More than 40 years earlier the very favorable outcomes in the Hong Kong DPAS placebo-controlled study were associated with a mean methadone dose of 97 mg per day.

Of course, reliance on dosages that have been demonstrated to be suboptimal for most patients is by no means limited to Hong Kong. For example, this practice has been shown to be widespread in the United States[83] and in the United Kingdom.[84]

Prohibition of take-home doses of methadone: As noted above, Hong Kong has never permitted take-home dosage, an option that would allow patients to receive their medication without needing to make a trip to a clinic on a daily basis. Competing priorities inevitably will lead patients, from time to time, to miss their daily dosage, with potentially serious consequences.

Complacency: There is always a danger of complacency when the response to a problem, though clearly not curative, is quite successful. This tendency applies no less to Hong Kong than to any other city or nation dealing with the drug problem. Of course, both the government and the community should welcome indications that the drug problem has declined. For example, the latest CRDA report notes that, "In 2014, the total number of reported drug abusers was 8,926, 13% lower than 2013 (at 10,241) and 37% lower than 2008."[85] Data such as these are an indication of the effectiveness of Hong Kong's anti-drug abuse measures as a whole—treatment of all kinds, community education initiatives, and efforts to limit importation and trafficking in drugs—but the methadone program would seem to deserve a significant share of the credit. Whatever the reasons for the downturn in reports, however, it tends to draw attention away from the drug problem that persists, and leads many, including governmental agencies, to question the need for maintaining treatment programs and the allocation of resources at the current levels.

A possible contributor to the drop in public concern over drug dependence is the government's decision to stop producing and circulating posters and frequent media announcements to stress the effectiveness and immediate availability of methadone treatment. (See, for example, Figure 2) It seems likely that such notices had not only encouraged those in need to seek help, but also reminded the community at large that addiction continued to be a major problem, though one that was treatable.

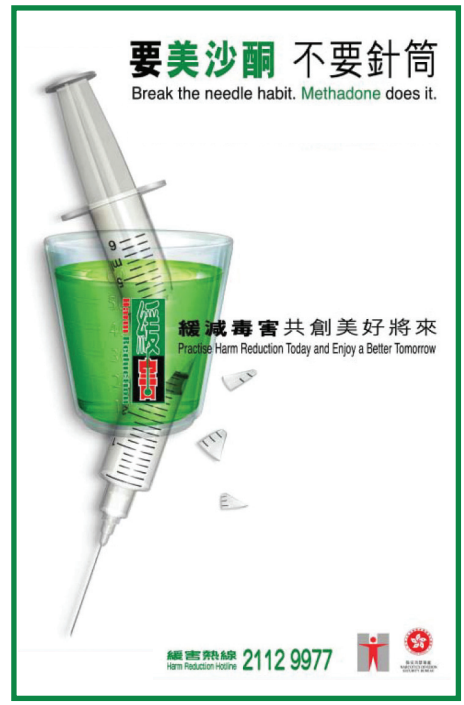
Those not reached: Hong Kong is currently concerned with what is deemed to be a large and growing number of "invisible" addicts. According to the most recent CRDA data, the median length of drug using experience of newly reported individuals (i.e., the time lapse between self-reported first use and coming to the attention of the CRDA) more than doubled from 1.9 years in 2008 to 5.2 years in 2014. The CRDA's interpretation is that this reflects, "the hidden nature of drug abuse."[86] The increasingly long interval between reported first illicit drug use and coming to the attention of the registry is perhaps in large measure due to the substantial increase in use of drugs *other than opiates* (especially ketamine and amphetamine-like substances). There is no treatment service even remotely comparable to the methadone program with the ability to attract (and subsequently to report to the CRDA) those with problems related to non-opiate drugs.

FIGURE 2.

"For a heroin problem call this number for same-day help!"

Source: Poster, Hong Kong, ca. 1978

"Break the needle habit. Methadone does it."



Source: http://www.rrc.gov.hk/english/target_drug.htm

Outcome evaluations: There are many more helpful and instructive outcome evaluation studies that could and should be done to assess the Hong Kong experience. In addition to assessing the impact of individual initiatives in absolute terms, comparative evaluations might assist in determining opportunities for improvement and optimal level of future governmental support. Such data could be analyzed by reports from various treatment providers and criminal justice system agencies before, during, and after intervention. Analyses such as these could also focus on population subgroups defined by age, ethnicity, gender, area of residence, etc. All of this could be accomplished with minimal additional allocation of financial or personnel resources, and could be undertaken almost immediately.

Overdose data: In most countries, deaths attributed to or associated with drug overdose are considered a key indicator of the extent and nature of the drug problem. Surprisingly, how-

ever, there apparently have been no studies of drug-related mortality in Hong Kong. This is a critical omission, but one that presumably could be rectified quite readily. Multiple informative and useful analyses could be produced if reports of suspected drug-related deaths were submitted directly to the CRDA by emergency rooms, police, and medical examiners.

VIII. Lessons Learned on Ensuring Prompt Access to Treatment of Opiate Addiction

Hong Kong's experience with the treatment and care of those living with an addiction to opiates offers a number of important lessons. Outpatient treatment with medication is only one of the responses called for, but it is a critical one if a community is to minimize the harm associated with drugs both for users and for the broader society. While outcome measures of services provided to those initiating treatment are obviously very important in gauging treatment effectiveness, there is another criterion that is equally important: the extent to which treatment is available promptly to all who want it, need it, and all too often die without it.

The lessons to be derived from the Hong Kong experience are underscored by considering both the differences and the similarities between Hong Kong and cities in other parts of the world. The differences, of course, relate not only to aspects of the drug problem per se, but also to geography as well as political, social, ethnic, and economic characteristics. They can be enormous, as exemplified by contrasting Hong Kong and New York City in the 1970s. These two cities, however, on opposite sides of the earth, had one striking commonality: their fundamental approach to the drug problem. In this regard they were in a league almost by themselves, each having been guided first and foremost by commitment and pragmatism. Both proceeded from the assumption that when it comes to treatment and the objectives of saving lives and benefiting the community, virtually any action is better than abandoning

those in need of care. Sadly, adoption of this seemingly self-evident philosophy remains the exception rather than the rule in most places.

A case in point is Cambodia, which with international assistance established its first methadone treatment clinic in 2010, a clinic that was a long time in coming. A letter from WHO/UNAIDS advocating medication-assisted treatment (MAT) was sent to the Chairman of the Cambodian National Authority for Combating Drugs (NACD) in July 2007. Almost one year later, in May 2008, the Ministry of Health advised NACD it had no objection to MAT, and after a few more months a methadone maintenance treatment "policy" had been drafted. It then took two additional years before an "implementation plan" was signed and finally, in July 2010, the clinic opened and the first patient was admitted.[87] The Cambodian "pilot," however, was destined from the outset to be high-threshold, costly, and, in terms of models for scale-up, nearly irrelevant. The designated staff comprised more than 20 doctors, pharmacists, nurses, case managers, and counselors, all of whom were to receive an intensive six-week training. The first-year's budget was U.S.$350,000, and the total capacity was set at 100 patients.[88] Not surprisingly, seven years later, in 2017, there was still only one methadone clinic in the entire country.[89]

Hong Kong effectively addressed the need for very large-scale treatment for opiate dependence with the resources available. As impressive as Hong Kong's efforts have been in absolute terms, the true magnitude of its achievement is best appreciated when understanding how the program was tailored to the local context.

IX. Conclusion

Considered in isolation, the Hong Kong success in massively and rapidly expanding its addiction treatment services might well be dismissed as an aberration unlikely to lend itself to replication elsewhere. Worse, it might be viewed as the prototype of a means to make treatment available to all—a model that should be slavishly adhered to in order to achieve similar outcomes.

There are, however, critical lessons to be drawn from Hong Kong's experience that do have very broad applicability:

- First is the recognition that in response to the complex problem of opiate dependence a multi-pronged approach is essential; no matter how convinced one is that a particular intervention will have great success, it is highly unlikely that it alone will be sufficient in responding to a problem as complex as drug dependence. Thus, it was never proposed that Hong Kong respond to the problem of opiate dependence solely by making treatment available. During his early consultancies, the author was told by local authorities that Hong Kong's approach to addiction was based on the acceptance of "four pillars": prevention and education, treatment, local law enforcement and international cooperation (most recently, a fifth "pillar" has been added: research).
- Secondly, while recognizing the limitation of any one approach, a critical element must clearly be the widespread availability of treatment.
- Thirdly, Hong Kong demonstrated the wisdom of considering the experiences of others, as well as seeking input from colleagues in other countries.

- Perhaps the most critical lesson is that this open-mindedness with respect to assessing what had (and had not) been accomplished elsewhere must be complemented by the determination and courage to reject any suggested course likely to preclude achieving, in the local context, the most critical goal: ensuring prompt availability of methadone treatment for all who want and need it.

One must hope that this seemingly self-evident objective, to ensure access to treatment for all who want and need it, will be adopted and pursued with equal success by the many countries that currently tolerate long waiting lists for treatment—to the extent they have treatment services at all.

Endnotes

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About the Author

For over 40 years, Dr. Robert G. Newman has been instrumental in planning and directing some of the largest addiction treatment programs in the world—including the New York City Methadone Maintenance and Ambulatory Detoxification Programs, which in the mid-1970s treated over 33,000 patients annually. He was an on-site consultant to the Hong Kong Government for almost four months in 1975, charged with recommending means of rapidly developing a very large-scale methadone treatment capacity; subsequently, over the course of more than ten years, he continued to make annual consulting visits to Hong Kong and report on his observations and recommendations.

Dr. Newman is President Emeritus of Continuum Health Partners, a $2.2 billion hospital network in New York City founded in 1997. From 2001 until 2013, he served as the Director of The Baron Edmond de Rothschild Chemical Dependency Institute of Beth Israel Medical Center.

Dr. Newman graduated with honors from the University of Rochester (NY) School of Medicine and Dentistry, and has a Master's Degree in Public Health from the University of California, Berkeley. From 1994 to 2012 he was Professor of Epidemiology and Population Health and Professor of Psychiatry and Behavioral Sciences at the Albert Einstein College of Medicine in New York.

Global Drug Policy Program

Launched in 2008, the Global Drug Policy Program aims to shift the paradigm away from today's punitive approach to international drug policy, to one which is rooted in public health and human rights. The program strives to broaden, diversify, and consolidate the network of like-minded organizations that are actively challenging the current state of international drug policy. The program's two main activities consist of grant making and, to a lesser extent, direct advocacy work.

At present, global drug policy is characterized by heavy-handed law enforcement strategies that not only fail to attain their targets of reducing drug use, production, and trafficking, but also result in a documented escalation of drug-related violence, public health crises, and human rights abuses.

Open Society Foundations

Active in more than 100 countries, the Open Society Foundations work to build vibrant and tolerant democracies whose governments are accountable to their citizens. Working with local communities, the Open Society Foundations support justice and human rights, freedom of expression, and access to public health and education.

Drug policies that are based on human rights and promote public health are a priority for the Open Society Foundations. Our efforts focus on promoting collaboration and expanding the range of stakeholders committed to drug policy reform, empowering drug users to advocate for their rights at the national and international level, and supporting research into the economic and social costs of current drug policies.

Globally Informed, Locally Responsive: Hong Kong's Common-Sense Approach to Expanding Methadone Treatment is the seventh in a series of publications by the Open Society Foundations' Global Drug Policy Program that documents positive examples of drug policy reform around the world. We hope these case studies will inspire policy makers and advocates in consultation with people affected by drug policy to design rights-centered policies that are scientifically sound and humane.

In the early 1970s, Hong Kong faced a major health and social crisis associated with a growing number of opiate-dependent, heroin-injecting residents. In response, the government created a program with two objectives: address the threats to a large and growing opioid-dependent population, and serve community interests in public health and safety. A multi-modal program emerged which included the rapid expansion of a large-scale methadone treatment system. *Globally Informed, Locally Responsive* documents the process of establishing this region-wide program, which, since 1975, has strived to make methadone treatment accessible to all who need and want it. It identifies the key decisions that were made to first evaluate best practices in other countries, and then boldly chart a treatment strategy that is responsive to local realities. The result is an impressive program with 20 clinics around the region. Not only has Hong Kong's methadone treatment approach provided an essential service to those living with opioid addiction, but it has also contributed to the successful control of HIV infection, avoiding an HIV/AIDS epidemic among people who inject.

In addition to drug policy reform, the Open Society Foundations work around the world to advance health, rights and equality, education and youth, governance and accountability, and media and arts. We seek to build vibrant and tolerant democracies whose governments are accountable to their citizens.

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