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STANDING COMMITTEE OF EUROPEAN DOCTORS
PREVENTIVE MEDICINE AND ENVIRONMENT SUBCOMMITTEE

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CONDITIONS OF PRACTICE FOR DOCTORS CARING FOR DRUG ADDICTS

- Dr. GRUNWALD -

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I. INTRODUCTION

1. A major public health problem common to all states

For several years now the fight against drug addiction has become one of the major public health problems of modern society.

As exchanges between states have become easier and more frequent the fight against harmful drugs has been raised to European level and it is acknowledged that in many respects it is just as much a world-wide problem.

Many European organizations, notably the CELAD[1], the EMCDDA[2] and the European Union's committees, gather and circulate information which enables co-ordinated solutions to the many questions raised by the fight against drug addiction and harmful addictive behaviour to be proposed.

The different treatment possibilities available to doctors in this domain are very important.

Starting from solutions tested and applied in the different European Union countries, it would seem to be useful for the Standing Committee of European Doctors to define what conditions are considered desirable for practitioners to follow, while at the same time the European Parliament studies the possibility of harmonizing the drugs legislation of the member states.

2. Drug addiction in Europe

Treating drug addiction is not made easier by its continual growth.

a) The drugs

They are becoming more and more numerous:

Opiates (the use of heroin concerns only 1% of the population of Europe but it remains the most dangerous drug), cocaine, hallucinogens (LSD-Mescaline), depressants (barbiturates, benzodiazepines).

For the last few years the drugs which are come across more and more frequently are, on the one hand, cannabis (the drug most commonly used on an occasional basis; between 5 and 30% of the population, depending on the country, have used it at least once), and on the other hand, amphetamines, ecstasy, and new synthetic drugs which are easily produced and therefore easily distributed.

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[1] Co-ordination Group on Drugs

[2] European Monitoring Centre for Drugs and Drug Addiction

These different products are included in the general term of "psychoactive substances".

Injecting drugs intravenously has its own danger added to that of the different products. Moreover, multiple drug addiction has practically become the rule together with other addictive behaviour, in particular alcoholism, the frequency of which is attested in all European countries, and nicotine addiction.

b) The users

Between 5 and 10% of the adult population of Europe say that they have used an illegal drug at least once.

Throughout the states of Europe, the use of harmful drugs affects young people (16 to 30 year olds, especially men) in particular and during the last few years:

- there has been an overall increase in the number of drug addicts (with the main focus being on the use of cannabis, ecstasy, psychotropic drugs and synthetic products, to a lesser degree cocaine, whereas heroin addiction has decreased considerably);

- there has been a decrease in the age of cases (it seems that between 4 and 30% of 15 year old schoolchildren in the European Union have already used drugs);

- there has been a broadening of the social classes involved even if serious drug dependency on opiates together with multiple addictions always affects the less socially integrated, indeed the most marginalized people;

- the close links between drugs and crime levels have also kept on growing.

Currently, drugs use is described under various headings:

- recreational and occasional
- abusive and harmful
- habitual with dependency

However, there are many intermediate cases, as well as possibilities of passing from one category of drugs use to another although this point remains under debate and is not universally accepted.

c) The consequences

The high death rate amongst drug addicts is well proven and has increased during the 1990's, from 8.8 to 63 per 1000 people per year.

The aggravating factors are heroin, associated alcoholism, a generally weakened state of health and even stopping substitution treatment. Injecting and the development of Aids have also played a considerable part.

The morbidity rate is linked to the product, to the means of administration, and to life style, with a considerable increase in hepatitis alongside the increase in Aids: 500,000 European heroin addicts are infected with hepatitis C, with rates of 60% hepatitis infection amongst drug addicts who inject in certain countries.

3. Principles underlying action against harmful drug addiction.

Because of the growing number of drug addicts and the growing variety of drugs used, because of the consequences of drug addiction on the spread of illnesses themselves considered social scourges such as Aids and hepatitis, and because of the social consequences of drug addiction, drug addicts pose health problems for the individuals concerned and for public health: it is a veritable social scourge of our modern society.

States have reacted on the one hand by rejection and repression, and on the other hand, more recently, by attempts at an overall approach to drug addicts themselves.

These actions are characterized in all European Union states by the constant interweaving of two areas of concern:

- socio-political and judicial concerns

Control of the manufacture of drugs and of their distribution, bans on trade and on the use of some of them are political decisions which are expressed in laws and regulations together with law enforcement measures motivated by the need to protect individuals and the community.

- medical and medico-social concerns

These lead to the treatment of those dependent on drugs, as the dependency is the cause of their deteriorating health, and exposes them to formidable psychological and physical complications.

This medical care has two objectives which are complementary and sometimes contradictory in their application:

- the abandonment of harmful addictive behaviour

- a reduction of the risks and consequences of dangerous drug addiction on both medical and social levels.

The widening of the concept of addiction and dependency which is useful in understanding drug addiction should not hide the specific nature of the problems posed by the use of different psychoactive substances compared to other particular addictions (alcoholism, nicotine addiction, etc.)

II. MEDICAL PRACTICE IN THE CARE OF DRUG ADDICTS

Throughout Europe, different situations influence the conditions of medical practice in the care of drug addicts.

1. Enforcement legislation

In all EU countries, manufacturing of, trafficking and trade in narcotics are totally forbidden. On the other hand only around half the states have an explicit ban on their possession.

Moreover, laws concerning their use also vary. Different countries hold different attitudes towards so-called soft drugs, notably cannabis which is the object of controversy in many countries.

There is a total ban on all illegal drugs in Finland, France, Greece, Luxembourg, Portugal (which returned to a policy of strict prohibition in 1993) and Sweden. This is also the case in the United Kingdom and Ireland.

In certain countries (e.g. France) there is the possibility of issuing an injunction requiring the person to receive medical help instead of imprisoning them for using drugs.

In Germany, a de facto decriminalization of the private use of hashish in small quantities has been agreed. The same move has been made in Belgium.

Only the use of these drugs in public places is punished in Spain. Decriminalization came into effect in 1993 in Italy, but was accompanied by different administrative measures.

In the Netherlands, a distinction has been clearly established since 1976 between hard drugs and soft drugs (cannabis, hashish) which can be sold freely in small quantities, but no legalization of these drugs is envisaged.

In concrete terms, it should be noted that the way legislation concerning drugs use is being applied in the different countries is leading to a reduction in the number of convictions and is giving priority to attempts at treatment and reintegration.

2. Medical practice

This seems to vary in accordance with the general conditions for practising medicine in each country. Laws lay down the possible treatments available to doctors, and the favoured attitude towards drug addicts. In all cases, a drug user who is drug-dependent and who consults a doctor is a “patient” who should be allowed to benefit from appropriate, attentive and suitably prolonged medical care. It is important to insist on this ethical and “humanist” (underlined by several delegations) aspect of the role of doctors.

It is also right to insist on the importance of the experience gained by each practitioner, as well as on the necessary personalization of the treatment programme which should be adapted to the particular condition of each drug addict patient.

- Medical support together with physical, psychological and even psychiatric care is considered to be indispensable in all states, as is, with or without hospitalization, the total or partial withdrawal from psychoactive substances which can be helped by the possible prescription of a temporary substitute. The treatment prescribed is often linked to treatment of associated alcoholism (e.g. in Sweden).

The length of treatment varies greatly from a few weeks to several years according to the case.

- Substitution treatments

These are used in cases of severe opiate-dependency, especially when the dependency is long-standing and resistant.

The objectives of these treatments are the same in the different states: to integrate the addict into a therapeutic process with medical follow-up of potential associated conditions; to stabilize the use of illicitly bought drugs; to limit the injection of drugs which can lead to the transmission of viruses and infections; to reintegrate the patient into society.

Methadone is the most commonly used substitute in Europe. Its prescription by doctors is free in certain countries (Netherlands), is sometimes controlled with respect to how it is handed out (e.g. in France) or is restricted to a number of authorized treatment programmes (Belgium, Finland, France, Slovenia, Sweden, etc.)

Some countries also use high-dosage buprenorphine in a less restricted process. Other products are also used or are being tested. All these treatments require good co-operation between the doctor who prescribes and the pharmacist who dispenses the products.

The results of these substitution treatments have not yet been fully evaluated, but it seems that they are having a beneficial effect on the mortality and morbidity rates of those treated, as well as on their social reintegration and on crime levels.

The future of those treated remains very unsure, however. The ambiguities of certain treatment programmes, the risks of people moving round different doctors and of an unofficial market in the drugs being issued, the iatrogenic risks of certain substitution products, especially in association with other medicines or drugs, should not be ignored.

These difficulties have obviously become all the more frequent because of an increase in the number of being prescribed treatments and because the issuing of drugs has been made easier. The risks of the prescribed products being misappropriated are more or less effectively limited by the dispensing measures and controls which have been set up (e.g. in Belgium and France).

- The controlled distribution of drugs has been implemented in certain towns, notably the dispensing of heroin under medical and social control. The justification put forward for this is basically social and it is aimed at cases who have been resistant to other treatments, including substitution. A reduction in the risks of morbidity and in crime levels has been noted. The results of these initiatives have so far only been assessed very indirectly. They seek moreover to give increasing priority to those on the edges of society, to provide them with medical and social care with a view to possible withdrawal treatment in the future (unfortunately very rare).

The exact role of practising doctors in such social procedures is in fact difficult to define clearly: projects seem to swing between simple distribution of products (with very little medical care) and genuine treatment programmes which are both diagnostic and therapeutic.

3. Treatment facilities and doctors' qualifications

Alongside each country's own health system, particular conditions exist in a certain number of states.

France authorizes only doctors practising in specialist centres to initiate methadone substitution treatment; buprenorphine substitution, on the other hand, is allowed in any doctor's surgery. Substitution treatments are given only within official facilities in Finland, Denmark and Sweden and in the large urban centres.

Appropriate treatments can be prescribed in any doctor's surgery in Holland. There are also specialist treatment centres for drugs problems.

Psychiatric doctors are involved most frequently in these treatments, often receiving specific training (e.g. in the Netherlands, Slovenia and Sweden). Other specialists are also involved, notably specialists in social medicine and general practitioners with training in this type of condition. A multi-disciplinary treatment programme is always strongly advised.

Relationships between practising doctors and other health professionals (pharmacists, nurses, social workers) are more or less formalized and are often considered insufficient. Because of this, multi-disciplinary care networks for drug addicts have been created in many regions.

Co-ordination with other professionals and with the administrative departments concerned (e.g. in the United Kingdom) is also necessary.

4. Social support facilities

These seem to be of prime importance in all EU countries. Different aspects are given priority in different countries:

- procedures for exchanging syringes and needles thereby limiting the risks of infection through injecting. The very positive results from these measures in the reduction of the morbidity rate are now confirmed.

- the approach to drug addicts who are highly marginalized and who do not ask for help has led to the creation of different types of places where contact can be made. For example in France there are “boutiques” and “sleep-ins” providing overnight lodgings, and a mobile social team whose sole role is to contact these people. In the Netherlands, “coffee shops” have permission to sell small quantities of soft drugs. The number of these coffee shops is due to be sharply reduced shortly, as well as the amount of drugs permitted to be dispensed (5g instead of 30).

- treatment programmes in prisons take place in various countries with the possibility of continuing substitution treatment, social follow-up and integration workshops on leaving prison.

5. International initiatives

For several years these have been giving direction to the fight against harmful drugs. Alongside the European directives concerning the illegal production of psychoactive substances and the financial aspects of drug addiction, various measures are having a direct effect on medical treatment programmes as a result of the work of the EMCDDA, of international committees of experts and of the European commission in applying the Maastricht treaty and article 129 of the treaty of Amsterdam.

The EU’s integrated action plan against drugs 1995-2000 notably includes an objective to reduce the demand for drugs through prevention and information. Actions targeted against the production and distribution of synthetic drugs have also been implemented.

Various concrete local actions, with an emphasis on specific preventative objectives and with European cross-border aspects, have been encouraged: networks of specialists in drug addiction in the Rhine-Meuse-Moselle region, training courses on prevention with international exchanges organized by federations of several European countries.

European drugs prevention weeks are also helping to develop awareness amongst the people concerned, especially the young.

These concerns are integrated into the studies, resolutions and agreements drawn up at world-wide level, notably in the United Nations.

An understanding of the realities of drug addiction on the ground remains difficult, however. The different epidemiological aspects of drug addictions which are common to the whole of the EU are difficult to define and compare because often different methodologies are used in different European countries.

6. Persistent uncertainties

On a practical level, the application of these different measures concerning the medical treatment of drug addicts comes up against the harsh reality of the facts: the growing number of different products used for addictive ends; the complexity of the different categories of drug users and drug-dependent addicts; the overlapping, and indeed divergence, of judicial, social and medical measures on these matters which lead to contradictory interpretations and decisions. There are also large disparities within the drug-dependent populations and in their treatment, not only between different EU countries, but also between different regions within each state (e.g. in urban centres, depending on proximity to the major routes of communication).

Various fundamental questions are still under discussion:

- the purpose of treatment programmes where no solution has been found to the dilemma between two attitudes, the first consisting of giving priority to an objective of withdrawal from drugs, the second tending to accept a simple policy of reducing the risks of harm to society and of physical complications, even though these two objectives are not necessarily contradictory in the long term.

- the increase in the use of psychoactive substances, considered as a social phenomenon. If it is necessary to fight against their harmful consequences, is it also necessary to be opposed to their private use when there are no major consequences? The recently demonstrated responsibility of certain substances in daily life (notably the role of cannabis in road accidents) is worthy of attention.

- multiple addictions: These represent, as we have seen, the real challenge at the moment. In many cases they concern the use at the same time or successively of several psychoactive substances. The risk of users of soft drugs progressing to addiction to hard drugs has been analysed in different ways by different countries; the differences seem to be linked to the behaviour of different groups of drug addicts. This escalation in drugs use is considered rare by some; on the other hand, other studies show that all serious heroin addicts have used less toxic drugs for three to four years beforehand.

The seriousness and therefore the importance of treating alcoholism and, to a lesser degree, nicotine addiction also remains a major problem when dealing with multiple addictions.

- Drug addiction and social environment: the development of serious drug dependency in marginalized social contexts makes the medical approach more difficult in the face of situations showing complex sociological phenomena.

III. DESIRABLE IMPROVEMENTS IN MEDICAL PRACTICE

The medical care of drug addicts is therefore characterized by its complexity due to these different factors illustrating the "cultural" and public health dimension of the questions about addictions in general, as well as the obviously supranational, European and world-wide dimension of the measures to be taken.

The persistent difficulties justify the proposal that the desirable conditions for medical practice in this domain be better defined whilst the cultural diversity and the organization of the health systems of the different states concerned should be respected.

1. Prevention of drug addiction and addictive behaviour

In the long run, this is the only solution to the continuing growth of dangerous addictions.

At the medical level, prevention, according to the definition recognized internationally, gives concrete expression to actions which belong to the larger field of "demand reduction" measures:

- primary prevention. The objective of a reduction in the demand for use of dangerous addictive products is envisaged from school age onwards. Repeated education of young people about the risks seems in fact to lead to significant changes in behaviour. This role is that of school doctors who can usefully be helped by family doctors.

- secondary prevention. This brings together a well targeted enforcement side along with support measures encouraging abstinence, withdrawal, together with, if necessary, a substitution phase. Suitable health education can also reduce the risk of people moving from the occasional use of psychoactive substances to real dependence.

- tertiary prevention in which substitution, control of and stopping injecting drugs and the necessary medical follow-up all have their place.

These different forms of prevention are all priority objectives which should be encouraged and supported in the different European countries.

2. Coherence of enforcement measures

Despite their acknowledged importance in various areas, policies which are solely repressive have been shown to be insufficient, even when accompanied by social measures (e.g. in France before 1995).

At present, the measures which need to be taken in the different countries must reconcile appropriate, necessary enforcement with useful preventative measures which differentiate between drug "suppliers" and "users" who are the victims of drugs. Several members of the Standing Committee wish to insist on the fact that a drug-dependent person is first and foremost someone who is "ill" and who must be allowed to benefit from medical treatment appropriate to his condition.

On the medical level, it would seem to be useful to insist on the importance of coherence and harmonization of enforcement legislation concerning the different types of addictive behaviour which are dangerous for others and for society, as well as for the individual. This principle applies as much to alcoholism and nicotine addiction as to the different psychoactive substances.

Scientific evaluations of the exact degree of harmfulness of the so-called soft drugs, especially cannabis, and an assessment of the relationship between the use of such products and other addictions, should also enable the policies of the different European countries, which currently differ on this matter, to be guided towards the same direction.

3. Social environment

All committee members insist on the pre-eminence of social measures in the fight against drug addictions. It is therefore essential that these are given priority.

Furthermore, the importance of stronger co-ordination between social and medical action, respecting the conditions of practice of each of these components, is emphasized in all states. The social approach must give priority to the medical approach, but the latter can be carried out only within a framework which provides all the guarantees necessary to quality medical practice.

4. Evaluation and research

In all EU countries, research into the medical treatment of drug addicts has been initiated out of local experiments; the lessons from these have then been applied to a greater or lesser extent on a regional or national scale.

Bearing in mind the different treatment strategies currently being proposed, it is essential that from now on medical treatment programmes should be based on research studies which have been duly evaluated and compared.

It is desirable that methodologies for studies be drawn up which can be reproduced in the different European countries and which are based on co-ordinated information and data collection.

These concerns are similar to the proposals made in 1997 by the directors of the EMCDDA.

5. Doctors' training

A specific training for practitioners treating drug addicts seems to be essential bearing in mind the distinctive nature of this matter.

This objective should be encouraged at international level. In the same way, moves towards cross-border European training which enable the realities of the different treatment methods tried out and used in the different EU states to be known in practice could be developed to a much greater extent.

6. Specific treatment methods

Specific treatment methods which are integrated into the general health system of EU states, yet which can be adapted to different local conditions, should be given priority jointly with normal medical practice: specialist treatment centres, multi-disciplinary care networks open to different concerned categories of doctors, pharmacists, social workers etc., especially for the start and follow-up of withdrawal and substitution treatments.

Such arrangements must not reduce the possibility of following different courses of action or the necessary professional independence of practitioners especially with respect to the choice of treatments they offer. This point is stressed in many European countries : the care of drug addicts must respect legal rules and also the usual professional rules of the practice of medicine.

As doctors bear responsibility for any medical action they undertake, we can only underline the appropriateness of drawing up precise definitions of the role of each participant in the care of drug addicts; this is another point on which different members of the Standing Committee have insisted.

The appropriateness or not of controlling the medical prescription of drugs is viewed in a variety of ways in the different European states with respect to the principle as well as the means. The important thing in fact seems to be that there should be reliable data available on treatments carried out and their results which can guide the development of treatment programmes considered to be useful.

7. Resources

The growing number of drug-dependent cases considerably increases the financial requirements needed.

The disproportion between the needs and the available means is getting worse: there is an insufficient number of doctors and social workers, an insufficient number of places for specialist care (even if it is only one of the possible treatments, the number of methadone substitution treatments planned in several EU countries is considerably lower than the estimated number of opiate-dependent patients who might benefit from it).

An increase in resources devoted to the fight against harmful drug addictions and addictive behaviour in general is currently a real health priority for individual countries as well as at European level.

IV. CONCLUSIONS

The survey carried out amongst the members of the Standing Committee shows that there are many medical problems raised by the care of drug addicts, that they are highly comparable between one country and another, and that there is much agreement on how to deal with them.

The desirable improvements in medical practice are dependent on political decisions.

The proposals of the Standing Committee which could be sent to the political authorities of the European Union deal with:

- the importance of the different, necessary prevention measures,
- the appropriateness of developing coherent enforcement measures,
- the vital importance of the social environment in treatment programmes,
- the confirmed need for thorough and comparable evaluations of different treatments,
- the importance of thorough training for the doctors concerned,
- the need to define the role of doctors in treatment programmes,
- an appropriate funding of these different actions which are a real health priority.

The efforts to be made in the domain of dangerous addictions are a measure of their seriousness.