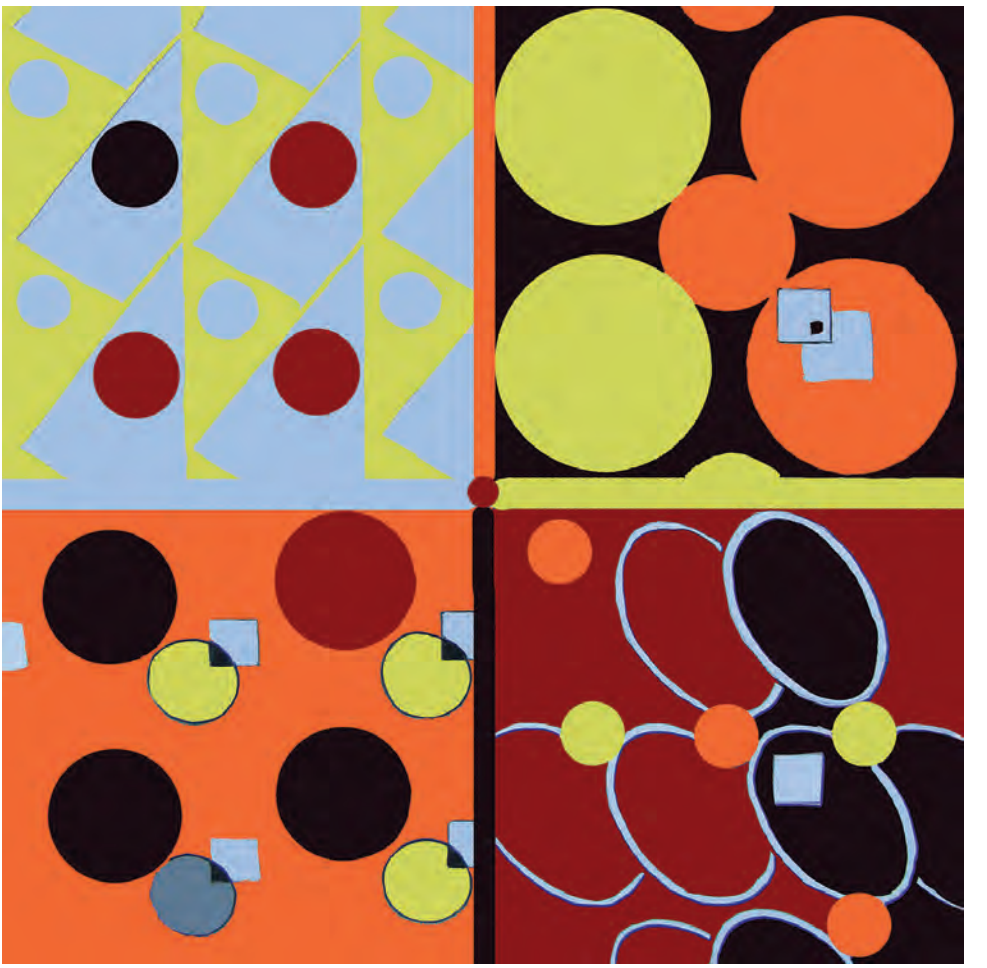
Pompidou Group



Treatment systems overview

Richard Muscat
and members of the Pompidou Group treatment platform

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Pompidou Group

The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (the Pompidou Group) is an inter-governmental body formed in 1971. Since 1980 it has carried out its activities within the framework of the Council of Europe and 35 countries are now members of this European forum, which allows policy makers, professionals and experts to exchange information and ideas on a whole range of drug misuse and trafficking problems. Its mission is to contribute to the development of multidisciplinary, innovative, effective and evidence-based drug policies in its member states. It seeks to link policy, practice and science.

By setting up its group of experts in epidemiology of drug problems in 1982, the Pompidou Group was a precursor of the development of drug research and monitoring of drug problems in Europe. The multi-city study, which aimed to assess, interpret and compare drug use trends in Europe, is one of its major achievements. Other significant contributions include the piloting of a range of indicators (treatment demand indicators) and methodological approaches, such as a methodology for school surveys which gave rise to the European School Survey Project on Alcohol and other Drugs (ESPAD).[1]

1. See the list of Pompidou Group documents and publications at the end of this publication.

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Introduction

This publication is an overview of the treatment systems of 22 member countries in the Pompidou Group, namely Belgium, Bulgaria, Croatia, Cyprus, Denmark, France, Germany, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Lithuania, the Russian Federation, the Slovak Republic, Slovenia, Sweden, Switzerland and the United Kingdom.

The background for this publication on treatment systems is the Work Programme 2007-2010 of the Pompidou Group which was adopted at the ministerial conference in Strasbourg in November 2006. The Work Programme states that one of the topics for the Treatment Platform should be "Improving knowledge on treatment systems". At the first meeting of the new Treatment Platform in Oslo in June 2007, the platform members decided to prepare a publication on the treatment systems in the Pompidou Group member states. The purpose was to make knowledge available about how treatment systems are organised in the different countries to facilitate bi- and multilateral co-operation and research.

With the help of the platform members a "framework" was constructed, describing what the report from each country should comprise. The request for the reports was sent out through the Permanent Correspondents of each member state and finally descriptions were received from 22 member states. Professor Richard Muscat from Malta, the co-ordinator of the Pompidou Group Research Platform, took on the task of reviewing the contributions and has written an introductory chapter summing up some trends in the reports and grouping countries from different parts of Europe.

We would like to take this opportunity to thank all the contributors from the member states, Professor Richard Muscat and the secretariat of the Pompidou Group for the work they have put into this publication.

The target audience for this publication includes policy makers, professionals/practitioners, user groups and researchers. It is our hope that the publication will be disseminated and used widely.

Overview of the treatment system in 22 Pompidou Group countries

As part of the activities of the Treatment Platform for the year 2008 a study was undertaken to find out what treatment options are available in the member countries of the Pompidou Group. In all, 22 countries, that is Belgium, Bulgaria, Croatia, Cyprus, Denmark, France, Germany, Hungary, Ireland, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Lithuania, the Russian Federation, the Slovak Republic, Slovenia, Sweden, Switzerland and the United Kingdom, have submitted a synopsis of the treatment options available based on the following framework:

- a short statement on the demographical context of the country, related to size and population;
- a short statement on the epidemiology of drug use, mortality and HIV/hepatitis;
- a short history of drug treatment with a focus on changes in recent years;
- an outline of the organisation of treatment services;
- a description of the services on offer;
- a short résumé of the special issues related to the country concerned;
- a short outline of the strengths and weaknesses of the services on offer;
- references.

It was recommended that this material be made available through a publication as it will represent a major output of the Treatment Platform's work in the first two years of this four-year work programme.

The country résumés have been preceded by an overall review of the material following the same format. However, to make the task more manageable, the countries have been grouped together in the following geographic categories: North of Europe (Denmark, Norway and Sweden), Centre and east of Europe (Bulgaria, Croatia, Hungary, Poland, Lithuania, the Russian Federation, the Slovak Republic and Slovenia), West of Europe (Belgium, France, Germany, Ireland, Luxembourg, Switzerland, the Netherlands and the United Kingdom), South of Europe (Cyprus, Italy and Portugal).

1 Demography

The reason for the introduction of this factor as an initial section is to provide a basic understanding of the size of the population in each of the countries in

question which in turn may then be related to the issue in question, namely the number of problem drug users that require treatment and hence the services provided.

1.1 North of Europe

Compared to Norway and Denmark, Sweden has nearly double the population (some 9 million inhabitants); Denmark has a population of 5.4 million and Norway of 5 million. In all the countries, however, a significant proportion of the inhabitants live in the capital cities: in Denmark the figure is 20%, while in Norway and Sweden it is around 10%.

1.2 Centre and east of Europe

The Russian Federation has the largest population by far, with some 141 million compared to the other countries contributing to this exercise. Poland follows with some 38 million and the rest have populations of between 2 and 10 million. In Bulgaria, Croatia, Hungary and Slovenia, 15-20% of the population live in the capital cities but this figure is lower in Poland, Russia and the Slovak Republic and is between 5% and 7%.

1.3 West of Europe

France, Germany and the United Kingdom have populations of some 61.8 million, 82.4 million and 58.8 million respectively. It would appear that some 4% of the population in Germany is based in the capital city Berlin but this figure increases to 13% when one looks at London and to 20% when one considers greater Paris, known as the Paris Region. The Netherlands has a population of approximately 16.6 million, Belgium approximately 10.4 million and Ireland approximately 4.2 million. The Netherlands has a relatively low number of citizens based in the capital city (some 4.5%), similar to Germany, whereas in Belgium it is around 10% and in Ireland, similar to France, it rises to some 24% if you consider Greater Dublin and 12% for the city itself. Luxembourg with a population of 0.48 million has about 20% of the population living in its capital city.

1.4 South of Europe

Italy has the largest population amongst this group of countries (some 59 million) which is comparative to that of the United Kingdom. Portugal and Cyprus have populations of 10.6 and 0.85 million respectively. In Italy and Portugal the ratio of those living in the capital to those outside is the lowest (between 1% and 6%). Cyprus has about 16% of the population living in the capital city.

2 Epidemiology of drug use

This section deals mainly with the estimated number of drug users in need of treatment or problem drug users in each country. It also takes into consideration the problem of morbidity, for example HIV, and drug mortality.

2.1 North of Europe

In Denmark and Sweden the average number of problem drug users or those addicted to drugs has been estimated to be 27 000 and 26 000 respectively. Alongside the fact that the population of Sweden is double that of Denmark, caution is also needed as the definition of problem drug use or drug abuse may be different in each of the countries concerned. If, on the other hand, the definition is similar it may be of interest to understand what Sweden has done in policy terms to arrive at such numbers.

Both Denmark and Norway have had similar numbers in treatment in 2006, between 12 000 and 13 000, and just below half of these have been for opioid addiction. Again in Sweden the numbers in treatment for such addiction are about half of those in Denmark and Norway.

With respect to morbidity and drug mortality, both Denmark and Norway have low incidences of HIV (around 5%) but high ones for hepatitis C, between 60% and 90%, and, respectively, some 266 and 195 drug deaths in 2006.

2.2 Centre and east of Europe

Russia in terms of sheer numbers has the largest estimate of problem users (some 500 000), of which 350 000 are deemed to be drug addicts and 300 000 are opiate addicts. Poland has estimates of 100 000-125 000 problem drug users of which 25 000-29 000 are addicted to opiates. In Croatia, 24 000 of those registered have problems due to use of psychoactive substances. Slovenia was estimated to have some 10 654 problem drug users in 2008.

With respect to numbers of those treated in 2006, there were some 13 198 in Poland, 9 777 in Hungary, 7 247 in Croatia and 5 571 in Lithuania. In both Croatia and Lithuania the majority were for opiate abuse whereas in Hungary and Poland this was not so.

Drug deaths in Poland are considered to be low – 290 for 2006. In Croatia, there were 94 reported deaths of which 65 were opiate-related, while in Slovenia, 39 deaths were reported of which the majority were due to opiates.

HIV prevalence among drug users is low in Croatia, Hungary, Lithuania, the Slovak Republic and Slovenia (less than 1%); in Russia and Poland it stands at around 12%. Data for hepatitis C from these countries show a much higher

occurrence, with figures of 80% for Russia, 50% for the Slovak Republic, 46.2% for Croatia, 28.9% for Hungary and 21.8% for Slovenia.

2.3 West of Europe

Estimates of problematic opiate use range from 285 566 in the UK to between 76 000 and 161 000 in Germany, between 24 000 and 46 000 in the Netherlands and 14 500 in Ireland.

Drug-related deaths in terms of numbers are highest in the UK (1 427) followed by Germany (1 296) and France (176), then Ireland with some 112 and finally the Netherlands with 99.

Luxembourg has an estimated 2 500-2 800 problem drug users and some 29 deaths per annum due to drug overdose.

In Luxembourg the HIV prevalence rate among injecting drug users is 2.5%, whereas for hepatitis B it is 24.7% and for hepatitis C it is 81%.

In Ireland, 1 in 10 injecting drug users and in the UK, 1 in 75 (1 in 20 in London) are estimated to be infected with HIV. The prevalence rates for France, Germany, the Netherlands and Belgium are similar and stand at 11%, 6%, 5% and 3% respectively. Drug users infected with hepatitis C are 50-68% for France, 60-80% for Germany, 54-84% for Ireland, 42% for the UK with the lowest in Belgium, some 30%.

2.4 South of Europe

Italy, with a population on a par with the UK, has estimated the number of heroin users to be 210 000, a figure lower than that recorded in the UK. Deaths are now stabilised between 500 and 600 per annum while in Portugal the number of drug-related deaths in 2006 was 216. The number of drug-related deaths in Cyprus was 17 in 2006.

In respect of HIV-infected patients the proportion of intravenous drug users amongst this group has dropped from 58.1% to 27.4% over the past ten years in Italy.

3 Short history of drug treatment

Without doubt some countries have a long history of treating individuals with problems related to drug use but others have only come to terms with this issue over the last part of the 20th century. In truth most services in the latter countries have their origins in the health care system, but over the years there seems to have been a switch in some countries to putting the responsibility for care under social services. In others it would now seem that this has gone back under the umbrella of health, as illustrated below.

3.1 North of Europe

Norway provides a good example of the chronology of change in the hosting of services for drug users, which first came to the fore in 1961. This was followed by the development of therapeutic communities in the 1970s and 1980s organised within the social welfare system. With the advent of the HIV epidemic, medically assisted treatment was piloted in 1991 and became available nationally in 1998. Under the 2004 reform treatment was moved to under the health authorities.

In Denmark, at present, it is the Ministry for Social Affairs (now Welfare) which is responsible for the medical and social treatment of drug addiction. All treatment at present is supported by acts of parliament and therefore all have a legal basis. In Sweden, too, treatment is regulated by the Social Services Act and the health care system is only involved in providing medical treatment.

3.2 Centre and east of Europe

In most countries of central and eastern Europe the acceptance of drug addiction per se has only come into being in the last part of the 20th century. Most problems related to drug use were handled by hospitals or psychiatric units based within the hospital set-up. Russia, from the late 1930s till the early 1980s, had an atropine coma therapy programme for drug addicts but now uses a range of psychopharmacological medications. In Poland, too, treatment was mainly hospital based, if acknowledged, but this all changed in 1978 with the first therapeutic community and the 1981 Youth Movement for Drug Prevention, that became the first legal entity in the field. Further development of the therapeutic communities ensued in the 1980s and to date there are some 80 of these in addition to some 50 outpatient-type services and 14 substitution centres.

Outpatient centres for drug treatment were developed in Hungary during the 1980s while in Slovenia this occurred in the 1990s. As far as inpatient facilities are concerned these include services within the hospitals as well as therapeutic communities. In a similar vein, this is also the position within the Slovak Republic with the hospital services providing the backbone along with the therapeutic communities that came into being in the 1990s based on those in the United States and Italy. The introduction of methadone occurred in the in 1990s in Croatia, Hungary, Lithuania, the Slovak Republic and Slovenia.

3.3 West of Europe

Most countries in this category have a long history of drug treatment and most has been documented elsewhere but it is of interest to note key points that have emerged over the latter part of 20th century. In Ireland, the focus

of treatment in the 1980s and 1990s was related to heroin and the introduction of substitution treatment. Now, however, a shift has occurred to cater for poly-drug use. In Germany, this in effect came into being in 1968 with the acceptance of addiction as a disease and current drug policy seems to reflect this as it is also seen as addiction policy. This too seems to be the way France has tackled the problem since the 1990s and more specifically in the 21st century with the new government plan for 2008-2011 that encompasses all substances. The UK has made an attempt to increase treatment availability through the Drug Strategy by setting up a National Treatment Agency in 2001. In 2007 the Treatment Outcomes Profile was also launched to monitor treatment results. In the Netherlands, treatment provision is the responsibility of the regions/local authorities and over the last year there have been a number of mergers between addiction service providers and those related to mental health. Moreover, the National Mental Health Organisation is responsible for the co-ordination of services provided by the regions/local authorities. Finally, in Belgium (like in Germany) there has been a shift to ensure access to the health care system for drug users. In addition, though personal use of cannabis still remains an offence, it is no longer a priority of the Public Prosecutor's Office following the introduction of a new policy on tolerance.

Luxembourg has had a methadone service in operation since 1989 but this was only provided with a legal framework in 2001. All drug services have been put under the responsibility of the Ministry of Health since 2000 and funding for service provision is provided by the same ministry to foundations and non-profit organisations who are accredited to an extent by a 1998 Act.

The drug problem in Switzerland came to the fore in the 1990s with the public discontent related to the open drug scene in Zurich. This was closed down in 1995 and to date public interest in drug matters has waned as demonstrated by the reduction in the number of parliamentary motions concerned with drug issues.

3.4 South of Europe

The drug issues came to the fore in Italy and Portugal in the 1970s. In Italy the main issue at that time was the heroin problem and this was tackled by development of therapeutic communities inspired by those in the US and the UK. Lately these have reorganised themselves as their numbers have begun to dwindle, to provide more far-ranging services, such as social, educational and psychological support. The other main form of treatment was the provision of methadone which met with some resistance after a number of years, but again treatment programmes were re-oriented with the advent of HIV. Specialised hospital treatment for addiction has been available in Portugal since 1973 but it appears that the main government intervention in the drugs field started in 1976 with the introduction of the Office to Combat

Drugs. In the interim period this has evolved from centres for demand and supply reduction to what is now known as the Institute for Drugs and Drug Addiction that came into being in 2002 and was granted legal status in 2007.

In Cyprus drug services came into being during the 1990s with inpatient and outpatient services. To date there are some 20 treatment centres mostly based in the capital city of Nicosia, six of which are government run, and all mainly catering for non-dependent and dependent users. Moreover, a shift from mainly inpatient to outpatient services is occurring, possibly as a result of the substitution therapies now on offer in such settings.

4 Organisation of treatment services

As hinted to in the above description of the history of drug treatment, it would appear that in some countries drug services fall under the remit of the Ministry of Health whereas in others this responsibility is the remit of the Ministry of Social Welfare.

4.1 North of Europe

In the three Nordic countries participating in this project, namely Denmark, Norway and Sweden, it is the municipalities that are responsible for the delivery of treatment. Moreover, it is the health care system that provides medical treatment either through the hospitals or interdisciplinary specialised treatment services based in the regional authorities. At state level it is the ministries of health and social welfare that provide policy direction and funds for treatment.

4.2 Centre and east of Europe

Treatment is mainly the domain of the Ministry of Health in Bulgaria, Croatia, Hungary, Lithuania, Slovakia, Slovenia and Russia. In essence, the organisation of services is divided into inpatient, outpatient and therapeutic communities. The latter are normally run by non-governmental organisations (NGOs) but in Slovakia and Bulgaria some outpatient facilities are also provided by NGOs. The exception to the rule seems to be Poland where the health care units are mainly the responsibility of NGOs – some 70%, with the remaining 30% under the charge of local government.

4.3 West of Europe

A number of different organisational systems have evolved to provide drug treatment in Ireland, the United Kingdom, France, Germany, the Netherlands, Belgium, Luxembourg and Switzerland. Some parts of each of these systems are common but others are not. For example in Ireland, policy is the responsibility of the Department of Health and Children and the management and delivery of services is the responsibility of the Health

Services Executive while the actual provision is that of both statutory and non-statutory organisations. In France, it is the Ministry of Health that offers three forms of treatment and care services for drug users, namely, specialist addiction treatment centres, general services (hospital and general practitioners) and a risk reduction scheme. In the UK it is the 149 local drug partnerships, equivalent to the number of local authorities, that provide the inpatient or patient service. This is similar to in the Netherlands, Germany and Belgium where the provision of services has been decentralised but, whereas in the UK all treatment is free, in France, Germany, the Netherlands and Belgium this is regulated by a form of health insurance or social insurance.

In Switzerland, the federal government is responsible for policy whereas it is the cantons that implement policy. Therefore it is these regional authorities that have the obligation under federal law to provide drug treatment.

In Luxembourg, the Health Ministry is responsible for drug treatment. Moreover, the services are provided by foundations and non-profit organisations funded and accredited by this ministry.

4.4 South of Europe

In Cyprus, Italy and Portugal it is the Ministry of Health that has the responsibility for treatment. In Italy, the national health system provides the regions and in turn these support the local health authorities for the necessary provision of services. In effect it is similar in Portugal where the Institute for Drugs and Drug Addictions within the Ministry of Health provides drug treatment through one central service and five regional ones. In Cyprus, the Anti-Drugs Council is responsible for the actual implementation of treatment services.

5 Services

This is the main part of the reports submitted by each country in this exercise. It is broken down into a number of subheadings namely: detoxification, evaluation/planning of treatment, treatment, gender issues and treatment within the criminal system. Moreover, the section on treatment is further subdivided into the following subsections: substitution, drug-free treatment, dual diagnosis treatment, in/outpatient treatment, drug and/or alcohol provision of treatment, availability/link to somatic and psychiatric treatment, rehabilitation services linked to treatment and treatment of young people.

What is most salient at this point in time is that in most countries such services as evaluation, dual diagnosis treatment, gender issues and treatment of young people are not as developed as other services. Substitution treatment would now appear to be available in most of the countries but the biggest issue here is that of coverage as in most countries this type of service

is available in the major cities but not so much outside. This would seem acceptable in those countries where a sizeable part of the population lives in the major cities and it is there that the major problems of drug use seem to gravitate, but this would not be useful where the proportion of those living in cities is low and diffusion of problematic drug use is apparent.

It is also worthy of note that most treatment facilities are geared towards treating heroin problem drug users but this to some extent is now changing with the presence of a different type of problem drug user seeking treatment.

5.1 North of Europe

In both Norway and Denmark detoxification and substitution services are well developed but it would appear that in the former these are orientated towards inpatient services whereas in the latter these are mainly based in outpatient services. In both countries there are relevant acts of parliament, medical guidelines and inclusion criteria for entry into a substitution programme. The latest development in Denmark is that of heroin assisted treatment following a review of such practices in the UK, Switzerland, the Netherlands and Germany. A law enabling the provision of heroin was passed in the spring 2007, came into operation in 2008 and was available for some 350 heroin users in 3-5 of the major centres out of 7 at a cost of some €8 million.

As the outpatient services are doctor-centred it would appear that the links to somatic, psychiatric and dual diagnosis facilities are possible in Norway and to much the same degree in Denmark. In both countries, drug and alcohol patients are treated in the same facilities and the social services are also involved in issues of housing, training and employment for better integration back into society. With regard to gender, treatment in specialist units is available in Norway as well as a law on compulsory treatment for pregnant drug users if they are a danger to themselves and their child. In Denmark, the law ensures that pregnant women with drug problems have access to medical and social care.

As to the provision of treatment in prison, both Denmark and Norway have now established units within prisons to oversee those with drug problems. In Norway they make up some 60% of the prison population.

5.2 Centre and east of Europe

Detoxification services are available in hospitals throughout central and eastern Europe but there seem to be differences in the availability of and emphasis on other types of treatment provided, be they inpatient or outpatient based. In Croatia and Slovenia a network of outpatient facilities are available through the public health care system in which substitution treatment is offered in the short, medium or long term. Bulgaria has started to

develop a similar network of treatment centres that now cater for some 2 910 individuals while in Hungary some eight centres (six in the major cities) provide methadone maintenance treatment and in the Slovak Republic this occurs in four large cities. This is similar to Lithuania in which the addiction centres of the primary health system within three major cities have a methadone programme in place, though with strict inclusion criteria. Moreover, in Poland, methadone is available via the public health care units but it is stated that these do not meet current needs.

Most residential or rehabilitation treatment in Poland is available via therapeutic communities and this to some extent is also reflected in Lithuania where 16 long-term residential centres have been established (280 beds). Hungary has some 13 long-term residential treatment centres.

In Russia the drug dependency centres in every region look after patients after their stay in hospital or other clinics. In many centres they provide psychotherapeutic services during the day or night as the case may arise. It seems that rehabilitation services are at the first stages of development.

The degree to which dual diagnosis services are available would appear to be limited in most countries in this group with the exception of Poland in which these services started to appear in 1998. though they are still few in number.

Russia, Poland and the Slovak Republic have treatment facilities available for the young whilst in the other countries these would appear to be part of the mainstream.

As to the provision of treatment in prison this is mainly drug free in Croatia, the Slovak Republic, Poland and Hungary, while in the latter the option of treatment rather than prison is given consideration.

5.3 West of Europe

It would appear that most services in Ireland, Germany, the Netherlands, Belgium and the UK are community based and are thus mainly outpatient. However, with respect to detoxification, this is done mainly in hospitals in France and Germany and medical residential units in Ireland and the UK, but in the Netherlands and Belgium it is still done in outpatient facilities with the exception in the latter for serious cases and “ultra rapid detoxification” (UROD) which is conducted in hospitals. Medical therapy includes all the known available pharmacological agents, such as naltrexone for example. Both the UK and Ireland note the shortage of such inpatient facilities. In Switzerland there are some 52 specialised units for all substances, 37 in hospital and 15 in outpatient settings. These facilities are evaluated in Switzerland and form an integral part of the service contract for the provision of drug treatment. In Luxembourg detoxification services are within the ambit of the psychiatric department within each of the five hospitals.

Substitution therapy is available in outpatient settings and methadone and buprenorphine are on offer. In France, Germany, Belgium and Switzerland it is the general practitioners that provide buprenorphine and/or methadone. In Germany there are many licensed doctors to prescribe methadone but this is not matched by the uptake. In Ireland this is also made available via the pharmacies to increase access as this seems to be a limiting factor. Thus the majority on substitution in Ireland obtain their methadone via the pharmacies (60% compared to 40% in clinics). Substitution treatment in Luxembourg has been available for a number of years but only lately, in 2001, has it been regulated by law. Three outpatient clinics and one therapeutic community are in place in Luxembourg.

Heroin assisted treatment is available in Switzerland, the UK and the Netherlands (815 places in 18 municipalities). Heroin assisted treatment is on offer in Switzerland for the severely dependent in 21 outpatient centres and 2 prisons. There is no heroin assisted treatment in Ireland and it was introduced only recently in Germany. Moreover, following a pilot study in Germany, relevant legislation has now been introduced so that such treatment is covered by the health insurance companies.

Drug-free treatment based on the 12-step model (the type available in therapeutic communities) is on offer in all countries and is mainly based on psychosocial support. Integration back into society is a key element in all these drug-free programmes. In Switzerland there are some 91 therapeutic communities which offer drug-free treatment.

In France, access to psychiatric services is either hospital-based or non-hospital care with waiting lists and in the private sector, psychiatrists are less willing to take on patients considered as difficult. With respect to those with dual diagnosis, these are catered for separately in Germany. In Ireland the primary health care teams are addressing this issue whereas in the Netherlands there are specialist centres addressing this problem. In Belgium, a pilot project was launched in 2002 to set up two units that cater for dual diagnosis. It is now being assessed to decide whether it should be increased to cover the country as a whole. Since most of the services on offer are based on an outpatient doctor-centred service the link to general health care is made easier in these countries. In Switzerland dual diagnosis patients are referred to the outpatient services.

France has put in place some 280 “young people units”, 217 of which are attached to the specialist outpatient drug addiction centres. Ireland provides outpatient counselling services for the young and has an adolescent-specific service in Dublin. In the Netherlands two organisations cater for this group with services in four large cities, while in Belgium this group is mainly catered for in outpatient services, though a small number of residential services are available. In the UK there is specialist treatment provision for the

young while in Germany there are few specialised facilities. As the demand is increasing there are a number of projects in place to address this issue under the banner "Release It". Young people in Luxembourg have access to two public services for adolescents.

Ireland has opted for drug liaison midwives in each of the three hospitals in Dublin to attend to the needs of pregnant drug users as well as having in place one therapeutic community similar to in France, solely for women, and one community-based programme. Moreover, in Germany there are some specialised services for women and 25 facilities for mother and child, while in Belgium this mode of operation is in place for residential rehabilitation programmes. Luxembourg provides one parenting support service for pregnant women and drug dependants. Services for women are mainly provided by hospitals in the big cities in Switzerland.

Drug facilities within the criminal justice system to some extent seem to be in place in all eight countries. Ireland and the UK have an arrest referral scheme in operation as well as what is known as treatment orders in preference to prison, while in the Netherlands this is known as quasi compulsory treatment. All eight countries offer substitution and drug-free treatment within the prison confines. In Luxembourg, psychosocial programmes and harm-reduction measures are available in prisons.

5.4 South of Europe

Detoxification services are well developed in Cyprus, Italy, and Portugal. Two types are available in Italy based on duration – 30 days or 30 days to 6 months – and the main treatment involves methadone as well as buprenorphine and the combination of these. Portugal has five public detoxification units and nine private ones. Detoxification in Cyprus is offered by two public entities and one private one was opened in 2007.

Substitution therapy is also provided by all three countries. In Italy and Portugal it is provided through outpatient services and as such is integrated with some form of psychosocial intervention. In Cyprus the first substitution programme became functional in 2007 with 50 places. This is reflective of the fact that Cyprus has mainly chosen drug-free treatment as the preferred option and as such has 11 drug-free services in place, at least one in each of the major cities (8 in total). Drug-free treatment in Italy mainly caters for problematic users but not addicts or young people. There are 73 therapeutic communities which are also a source of drug-free treatment in Portugal. In Italy they are also well established but not as popular as in the 1990s.

Dual diagnosis services are available in 80% of the regions in Italy based in in/outpatient services but they depend very much on the co-operation in the region between the mental health services and the addiction services. However, in Portugal these services are mainly to be found within

the detoxification units and/or therapeutic communities. No facilities for patients with dual diagnosis are available in Cyprus.

While services in Portugal cater for all addictions, in Italy separation of services is the order of the day. Rehabilitation linked to treatment is also well covered through involvement of the social services in the overall integration programme. Services for young people are available through outpatient settings in Italy and national youth institutes in Portugal.

Services for women are provided in some regions of Italy and by the outpatient centres for drug addicts in Portugal. Cyprus has one planned residential centre for women.

Again, as in the countries of western Europe, drug services within the criminal justice system are in place to varying degrees in Italy, Portugal and Cyprus. Italy provides treatment in a therapeutic community as an alternative to imprisonment, including treatment of minors. Italy also has an arrest referral scheme in place while drug-free areas for addicts are established in prison. Portugal provides drug-free treatment as well as substitution treatment within the prison setting. Cyprus provides psychosocial programmes for drug dependants in prisons.

6 Special issues

This section was introduced to enable countries to highlight country-specific treatment issues. However, most of the countries reported on development of treatment guidelines as their main issue.

6.1 North of Europe

In Sweden, the National Board of Heath published guidelines for treatment of drug misuse and drug dependency in 2007. However, most of those who are involved in treatment services and are aware of these guidelines have yet to implement them. The government has now stepped in with an agreement with the Association of Regional Authorities to enable the process of implementation and this has also come with a significant budget. The county authorities and the National Board of Health and Welfare have responsibility for monitoring the implementation of the national guidelines for treatment. Norway is currently developing treatment guidelines for specific types of treatment, such as medically assisted treatment (also for pregnant drug users), dual diagnosis, and treatment for children and families. Thus, the Ministry of Health and Care Services has requested the Directorate of Health to close this loophole by developing national guidelines for all the treatment areas.

6.2 Centre and east of Europe

Bulgaria is in the process of developing a nationwide treatment network of centres through which treatment programmes are made more accessible. Poland has been going through a process by which standards of care are developed that cater for patients' rights, continuity of care, evaluation procedures and individual treatment plans, amongst others. Consequently, the development of these standards of care provides the opportunity for accreditation of those centres that fulfil such standards. It is envisaged that the implementation of this system will go ahead in 2008 even though this will be voluntary. However, it will be in the interest of the care centres concerned to join the scheme as this will further enhance their chances of obtaining finances from the National Health Fund. Patients' rights are another major issue as these are governed by the Act of Law on Mental Health Care. A spokesperson for patients' rights has been appointed by the Minister for Health, and to a large extent deals with complaints related to the act, but these would appear to be generally in relation to under-age addicts in care and involve issues relating to school requirements, limited family contact and lack of information on patients' rights that would normally be available to other patients.

Russia too has developed what are termed "standards for the diagnosis and treatment of drug dependent patients" and included in these is the total abstinence of alcohol and drugs. These are based on the latest scientific findings and those from clinical practice.

Slovenia has now introduced the combination therapy Suboxone (naloxone and buprenorphine) as well as an evaluation of their substitution treatment programme.

In Lithuania, a number of issues have been raised including: poor accessibility to treatment, the underdeveloped maintenance treatment programme, the lack of financial support to purchase medications and the lack of guidelines for the treatment of individuals with problems following psychoactive use. With regard to the Slovak Republic, the issues highlighted are those of education and research and here the Institute for Drug Dependencies is responsible for organising courses for counsellors in drug dependencies, for conducting research along with the universities, and for disseminating the relevant information through local publications and regular yearly conferences.

6.3 West of Europe

Ireland has raised four issues here which are as follows: better progression of opiate users on methadone substitution, alcohol, quality assurance and human resources. The first of these will be tackled following a report of the working group on drug rehabilitation which suggested that rehabilitation

uses a case management system and protocols to facilitate inter-agency arrangements, and introduces service level agreements. As alcohol is only an item for those under 18 in the National Drugs Strategy, the Department of Health and Children is now studying whether a combined strategy for drugs and alcohol is the way forward. A quality assurance scheme has been recommended to cover all four tiers found in alcohol and drug services and work on this started in 2007. Finally as regards human resources, both general practitioners and pharmacies contribute to service provision on a voluntary basis and, to increase the take-up outside Dublin, a national general practitioner co-ordinator has been put in place to resolve this issue.

France has highlighted the success of the risk reduction measures put in place for opiate users to combat the spread of HIV but now makes the point that measures need to be stepped up to prevent the spread of hepatitis C and to stop people becoming addicted in the first place by preventing trafficking in substitution products and prescribed drugs.

Both in Germany and the Netherlands the issue of the provision of medication assisted therapy by general practitioners and psychosocial counselling has received attention in that it is argued that these services need to be better co-ordinated. The latter have also issued some guidelines on this very issue. Germany also made reference to another area in which some attention is needed, namely those over 60, whereas the needs of the young seem to be catered for by the creation of youth and addiction support centres.

The UK has put significant emphasis over the past decade on drug treatment together with the move to improve quality of care through the development of guidelines and better regulation. In Belgium the emphasis needs to be shifted back towards prevention as this would appear to have lost out to treatment and risk reduction.

Switzerland highlights the success of implementation of harm-reduction programmes. For example, the consumption rooms, which now also cater for injecting as well as inhalation, have achieved one of their many goals, which is that of reducing the consequences of drug use and its public visibility. Consequently, there has been a rise in the number of harm-reduction services that to date total some 200.

6.4 South of Europe

The key issues highlighted by Italy and Portugal mainly refer to success stories following the implementation of harm-reduction programmes. In the case of Italy, however, it is the rise in cocaine use, a doubling in the prevalence rate, that takes centre stage and, as a result, there has been an attempt by the services, outpatient and residential, to provide treatment for this group. The Ministry of Health has also now launched a Cocaine National Project to further supplement efforts in this direction. Portugal

has had its programme on syringe exchange evaluated and it is said to have averted 7 000 new HIV cases.

The issue highlighted by Cyprus is that of migrants, who now form significant numbers of the treatment population. No studies have as yet been undertaken, however, to assess their specific needs.

7 Strengths and weaknesses

This section is not a SWOT analysis but an attempt by a number of countries to cite what over the years has resulted in a service that addresses the needs of the target audience and also what can be done to step up the effort in instances where it would appear the situation needs attention.

7.1 North of Europe

In Norway the quality of service is overall high and is available in most of the country but the availability of services in particular parts of Norway, namely in the western and northern parts, is limited. The main shortfall of the Norwegian system is that time to enter into treatment is considered to be too long.

7.2 Centre and east of Europe

In central and eastern Europe, it would appear that the main issue involves the fact that the treatment systems are in development and thus there seems to be an imbalance between those available. For example, Hungary reports positives that include low drug mortality, as well as the low level of HIV and hepatitis infection among injecting drug users. The community addiction care approach is also another good factor but the fact that there are limited services, especially in regard to reintegration, is considered to be a weakness. Other issues include the lack of services throughout the country, the limited number of low-threshold services and children and adolescent slots in treatment, the lack of training for professionals, and limited evaluation and finance.

Poland reports the positive changes in the 1990s that led to the financing of drug treatment through the National Health Fund which then provided the background for concerns over the standards of services on offer. This resulted in positive changes with the introduction of compulsory training for drug therapists. This year the next step in the evolution of services will be the introduction of evaluation as a means of gaining accreditation. On the negative side, there still seems to be an imbalance with the type of service on offer and the limited development of substitution treatment and other forms of assistance. In turn, Lithuania also acknowledges the fact that with the development of the Mental Health Strategy put forward by the Ministry of Health, this resulted in the development of specialised centres for addictive

disorders accompanied by a legal framework and standards for treatment. The downside would appear to be insufficient funding and resources to implement these measures and public intolerance of drug dependency.

As a result of the outcome of the evaluation study on the substitution programme in Slovenia, it is apparent that the programme per se is well organised and accessible to most drug users; up to a third do in fact make use of this treatment service. On the other hand, better co-operation between disciplines and sectors is suggested as well as an improvement in psychosocial treatment.

The upside of the treatment system in the Slovak Republic is that it is well designed, free of charge and does not have any waiting lists for those requesting treatment. On the other hand, the limited access to treatment for hepatitis C is of concern, as well as the lack of specialised wards for adolescents, methadone detoxification and maintenance in prisons, unavailability of naltrexone and professional staff turnover.

7.3 West of Europe

Ireland cites three positive aspects with respect to the treatment services on offer, namely: the high degree of qualified staff, the services in themselves are client-centred and thus address clients' needs and all of this is based on a highly successful partner approach between statutory, voluntary and community sectors. However, with increased poly-drug use and the spread of opiate use, the services are under strain to re-orientate as well as to increase their capacity and possibly their number.

In France the major positive aspects have been the ease of access and availability of substitution treatment with the exception of in prisons, the widespread availability of care in general, the fact that it also provides for anonymity and in effect is free of charge. Monitoring and evaluation is said to be limited and there is a need for better co-ordination between the health and social sectors and within the health sector per se between addiction and psychiatric services.

Germany, like Ireland, operates its treatment system through skilled professionals and it is also seen to be comprehensive in that the treatment centres attempt to take into account all of the problems of the individual in order to better treat and reintegrate them back into society. One caveat with the system is that of substitution treatment in prison and also the need for better co-ordination between the funding agencies and the treatment providers.

It is of great satisfaction to the Netherlands that, following years of research into what treatments work, this information is now percolating through to the professionals on the front line. In addition, the increase in professional education on this very issue both in quantity and quality is notable. From

an operational point of view, interventions in methadone distribution that now ensure medical and psychosocial care have been put in place. What is outstanding at present is a national empirical review of what types of treatment are on offer in the Dutch system.

Belgium cites the success of its system, which is the number of treatment options available as a response to the different drug habits among its citizens, but then reiterates the need for better co-ordination even though public funds will be needed and these are limited.

As far as Switzerland is concerned the positive experience includes continuing professional exchange with countries such as Germany, the Netherlands and France and to some extent with the United Kingdom, Ireland and the US. On a less positive note, Switzerland flags the difficulties encountered in trying to co-ordinate services within a framework in which three languages and possibly as many cultures operate.

7.4 South of Europe

In Italy and Portugal the services provided by the centres are the positive points but in Italy it is said that the need to diversify is gaining momentum and that there is a need for better integration of professional education. Other positive points cited by Portugal include varied treatment options and the fact that these are client-centred. In the case of Italy, positives include the good collaboration between public and non-governmental services. Portugal notes the lack of human resources, the costs of certain medication and the distances involved for clients to attend clinics as possible weaknesses of the treatment system in operation.

Considering all the issues in Cyprus, the positive outcome is the advent of the Cyprus Anti-Drugs Council which has resulted in an improvement in the co-ordination of the provision of treatment. However, there still seems to be room for improvement, although the first substitution programme has come on line, for other harm-reduction services to be implemented. This is also true for intensive outpatient treatment programmes for adults, co-morbidity services, services for women, cocaine programmes for adults and professional requirements for those working in the addiction field.

North of Europe

Denmark

1 Demography

Denmark covers an area of some 43 098 square kilometres and houses a population of 5.4 million inhabitants which gives rise to a population density of approximately 127 inhabitants per square kilometre. The capital is Copenhagen with 1.21 million inhabitants in the metropolitan area. Other major cities are Århus (295 000), Odense (186 000) and Aalborg (163 000).

In Denmark there are three levels of authority. Public duties are shared by the state, the five regions and the 98 municipalities.

With regard to the medical and social treatment of drug abuse, it is a national responsibility to regulate, co-ordinate and give advice to the decentralised providers of treatment services. In addition, it is a national responsibility to provide treatment within the criminal system. Thus national policies are determined, legislation is adopted, guidelines are defined and control is performed at national level.

The regions, which have an average population of 1 060 000 inhabitants, are responsible for hospitals and psychiatric treatment as well as the primary public health care scheme (general practitioners (family doctors) and private practising specialists).

The municipalities, which have an average population of 55 000 inhabitants, are the primary access point to the public sector for citizens. Social services and some health care services are municipal responsibilities. Thus the provision of medical and social treatment for drug abuse is a municipal responsibility.

2 Epidemiology of drug use

The most recent estimate of the number of drug addicts was made in 2006. This estimate shows that the number of drug addicts in Denmark is 27 000, of which more than 7 000 are cannabis users alone. Compared to 2001, it appears that the estimated number of drug addicts has stabilised. The statistics do not include experimental drug consumption, but estimate the number of individuals with a more constant use of drugs leading to physical, mental and/or social injuries. Actual drug addicts are thus included in the estimates as are the drug addicts in substitution therapy.

There continues to be an increase in the number of drug addicts admitted for treatment, although during the past few years there has been a “halt” in the rising figures. A total of 13 441 people were admitted for treatment for

drug addiction in 2006, which is a slight increase of close to 1% compared to 2005. The number of drug addicts admitted for treatment for the first time in 2006 was 24% of all those who had been admitted in 2006 (1 329 of a total of 5 426 people). The ratio of men to women in treatment is 3:1. The mean age when admitted to treatment is 32 for men and 33 for women.

The young population in particular accounts for the group of newcomers admitted to drug treatment and, typically, their problems revolve around drugs such as cannabis and/or central stimulants.

Of the 13 441 people in treatment for drug addiction, 6 300 were in medical treatment for opioid addiction (5 700 methadone, 600 buprenorphine).

Heroin and other opioids are still the most frequently used drugs among the clients in treatment, but cannabis is more used today by many seeking treatment. A vast majority of drug addicts seeking treatment use several drugs. In 2006, 42% reported that they had used more than one drug prior to admission, which implies that almost half of those admitted for treatment were poly-drug users before starting treatment.

Since 1997, there has been an 80% decline in the number of people under 30 years of age in treatment for opioid addiction.

The central stimulants appear only moderately as the primary drug of use for drug addicts admitted for treatment in 2006. Only 6% report amphetamine, 5% report cocaine and 1% report ecstasy as their primary drug of use. These drugs are therefore being used mainly as secondary drugs of use. Cannabis was the primary drug of use for 24% of those admitted for treatment, but it is also a very widely used secondary drug.

The incidence of drug-related deaths has been high, but constant, for the past few years. In 2006, 266 drug-related deaths were registered in the National Commissioner's Register.

Of the 266 deaths in 2006, 83% were caused by poisoning with one or more drug, mainly by fatal poisoning with heroin, morphine or methadone in combination with another drug. Twelve of the deaths caused by poisoning in 2006 were caused by either cocaine or amphetamine. Studies have shown that on average, 3.3 drugs are involved in each drug-related death.

Of the 266 drug-related deaths, 17% were not caused by poisoning, but were due to drug-related violence, accident or disease.

The prevalence of HIV is low, approximately 5%. The approximate prevalence of acute hepatitis A is 1%, of hepatitis B 35% and of hepatitis C 85%. The figures for hepatitis are probably inaccurate due to an insufficient number of registrations.

3 Short history of drug treatment

The responsibility for medical and social treatment of drug addiction has, since 1 January 2007, been assigned to the municipalities. The municipalities refer clients to all kinds of drug addiction therapy, whether it involves slow withdrawal, outpatient treatment, substitution treatment or inpatient treatment, and whether or not treatment is administered at their own institutions or in a private institution. The vast majority of treatment against drug addiction is targeted at drug addiction that is closely related to social problems.

The medical treatment for opioid addiction (substitution treatment) is defined by paragraph 142 of the Act on Health (*Sundhedsloven*. Law No. 546 of 24 June 2005) and paragraph 41 of the Act on Authorisation of Health Personnel (*Autorisation af sundhedspersoner og om sundhedsfaglig virksomhed*. Law No. 451 of 22 May 2006).

A law-based guideline from the National Board of Health specifies the care and conscientiousness that must be exercised by doctors when treating drug addicts with medical treatment (substitution treatment) for opioid dependency (*Vejledning af 8 juni 2007 om ordination af afhængighedsskabende lægemidler og om substitutionsbehandling af opioidafhængige* [National Board of Health Guideline of 8 June 2007 concerning the prescription of addictive substances including substitution treatment for opioid dependency]).

Only doctors in the municipality and in the criminal system can prescribe long-term opioid substitution treatment. Since 1985, the National Board of Health has registered the number of clients in long-term methadone treatment. There has been an increase in the number of people in long-term substitution treatment for opioid addiction. During the years from 1993 to 1995, the figures stabilised at approximately 3 000 per year. Since then, the number of individuals in long-term substitution treatment has doubled to 5 700 people receiving substitution treatment with methadone and approximately 600 people receiving substitution treatment with buprenorphine.

As from 2007, doctors are required to register patients in long-term buprenorphine treatment.

The medical treatment of drug addiction consists of:

- diagnosis and treatment of addiction, medical treatment for opioid addiction (buprenorphine, methadone (oral and injectable));
- diagnosis and ensuring of treatment for psychiatric and somatic comorbidity to drug addiction, for example mental illness, hepatitis, HIV, injection sequelae, general health problems, and also counselling on contraceptives.

The medical treatment of drug addiction has been an area characterised by much diversity, primarily due to the difference in medical background and the organisational framework of the treatment programmes. In 2004, the government received approval to reserve funds to conduct quality assurance appraisals and to put in place procedures for the development of substitution treatment. In this context the National Board of Health has developed a new medical guideline, published at the beginning of 2008. The overall purpose of the guideline is to reduce morbidity and mortality among drug addicts. The new guideline will support and strengthen the medical treatment of drug addicts through specific guidelines for substitution treatment of opioid dependency and the medical core services associated with the treatment for drug addiction.

As of 1 January 2003, drug users aged 18 years and over have been guaranteed social treatment for drug addiction. According to this guarantee, drug users may request to be put on a treatment programme no later than 14 days after contacting the municipality. A mechanism for free choice was also introduced, whereby the drug user can choose between treatment programmes provided by either public or private institutions. As a follow-up to the treatment guarantee, a ministerial order was issued together with guidelines on quality standards for social treatment of drug addiction.

On 12 May 2005 the Danish parliament adopted an amendment to the Social Services Act, which stipulates that, in special cases, the Minister for Social Affairs (now the Minister for Welfare) is authorised to establish rules on the guarantee of social treatment for drug users under the age of 18 years. The law came into force on 1 October 2005. The Minister for Social Affairs issued a ministerial order on 11 August 2005, which also came into force on 1 October 2005. The purpose of the law is for the municipality to immediately arrange for the young person to be admitted for treatment for drug addiction. Young people with serious drug use problems must be put on a treatment programme within 14 days of contact, in the same way as adult drug users are provided with the same stipulation with regard to social treatment.

4 Organisation of treatment services

According to the legal framework, the right to prescribe substitution treatment for opioid addiction is restricted to certain groups of doctors. There are no specialist qualifications in addiction medicine.

At the state level, the Ministry of Health and Prevention is responsible for matters concerning medical treatment for drug addiction. However, the responsibility for providing medical treatment for drug addiction rests with the 98 municipalities, whereas the responsibility for hospitals, the psychiatric system and general practitioners rests with the five regions.

The Ministry of Welfare is responsible for the government's social treatment according to Act No. 1117 of 26 September 2007 on social services. The provisions of this act include regulations on social treatment of drug abuse. At the local level the municipalities are responsible for their specific treatment and prevention programmes. The municipalities are assisted by the central authorities in matters such as monitoring, overall guidelines, documentation and knowledge sharing. The Ministry of Justice is responsible for treatment of drug addicts within the criminal system.

5 Services

5.1 Detoxification

5.1.1 Outpatient settings

In the municipal centres for treatment of drug addiction there is a slow reduction of doses of substitution medication according to an individually matched time schedule. About 10% become drug free/abstinent in outpatient settings.

5.1.2 Inpatient settings

In acute care inpatient settings, general and psychiatric hospitals can provide medically managed intensive inpatient detoxification and the link to the treatment system for drug addiction for further treatment of the substance abuse disorder.

5.1.3 Planned detoxification

Stabilisation and dose reduction primarily takes place in outpatient settings, followed by further dose reduction/detoxification combined with rehabilitation in inpatient settings in the treatment system for drug addiction. Inpatient treatment takes place in so-called 24-hour treatment centres primarily under the supervision of social workers and drug counsellors and with only part-time medical supervision on a consultation basis. Approximately 1 000 people per year are admitted to inpatient settings for detoxification with the goal of becoming drug free/abstinent. About 40% complete a successful detoxification/rehabilitation programme. The rate of relapse is high, however, about 70%.

5.2 Evaluation/planning of treatment

5.2.1 Mandatory central monitoring of the numbers of people in long-term opioid substitution by the National Board of Health with publication every year

According to the Act of Authorisation of Health Personnel, doctors prescribing long-term opioid substitution treatment are obliged to register their

patients every month with the National Board of Health. The results are published once a year.

5.2.2 New guidelines for the medical treatment of drug users and perspective of future evaluation/planning

Based on the government's pooled funds settlement for 2004, an amount has been set aside to conduct quality assurance appraisals and development of substitution treatment. With these funds, the National Board of Health has conducted an overall review of the medical treatment of drug users in substitution treatment. This review led to the publication of new medical treatment guidelines at the start of 2008. The purpose of the guidelines is to support and strengthen overall activities through guidelines for substitution treatment itself, as well as a description of the health-related problems seen in drug addicts and the medical core services associated with the treatment.

The guidelines will provide doctors with the necessary tools with which to assess and ensure treatment of mental and physical problems related to drug addiction, prevention of unwanted pregnancy, contraceptive counselling and prevention of sexually transmitted diseases, as well as treatment of pregnant drug users.

The guidelines and compendium of recommendations will contribute to ensuring a consistent and acceptable quality of the most significant medical core services associated with substitution treatment of opioid addicts. In the long term, the guidelines and their recommendations will be able to form the basis for ongoing quality development and in turn these will provide the basis for organisational planning of treatment in the municipalities.

Specific information on inpatient treatment can be gathered from the DanRIS monitoring system, which has been in operation since 2000.

Research conducted under the auspices of the Ministry of Welfare is primarily targeted at evaluation of social programmes in order for these programmes to provide measures of effect, research-based knowledge and accompanying documentation. This research is very user and methodology oriented and is related to evaluations of specific services, such as trials with new projects.

5.3 Treatment

5.3.1 Substitution treatment

The medical treatment for opioid addiction (substitution treatment) is defined by paragraph 142 of the Act on Health (2005) and paragraph 41 of the Act on Authorisation of Health Personnel (2006).

The right to prescribe long-term opioid substitution treatment is restricted to certain groups of doctors. Law based guidelines from the National Board of Health specify the care and conscientiousness that must be exercised by doctors when treating drug users in medical treatment (substitution treatment) for opioid addiction. The current guideline is "*Vejledning om ordination af afhængighedsskabende lægemidler og om substitutionsbehandling af opioid afhængige*" of 8 June 2007.

The admission criteria for medical treatment of opioid addiction are the criteria for opioid dependency set by the International Classification of Diseases (ICD-10) of the World Health Organization (WHO). Substitution treatment is part of a social plan and therefore the decision to offer substitution treatment has to be made taking into account whether substitution treatment is relevant in relation to realising the goals of this social plan. Pregnant women, who want to continue their pregnancy, should be offered substitution treatment if detoxification is not realistic.

There is no limitation in terms of duration of medication assisted treatment for opioid dependency. A decision to interrupt the treatment against the will of the patient has to be considered carefully. Whether the treatment is worthwhile or not is a medical decision and treatment should be resumed when the patient is motivated and an agreement can be reached concerning the treatment plan.

On 8 June 2007, the National Board of Health published revised guidelines on the prescription of addictive medication and treatment of drug users. The guideline contains new medical recommendations concerning substitution treatment for opioid use, including new recommendations on the choice between methadone and buprenorphine and the use of injectable methadone. Due to buprenorphine's safety profile, the guideline recommends that buprenorphine should be prescribed as the first choice and that as many opioid addicts as possible should be treated with buprenorphine.

5.3.2 Drug-free treatment services

Outpatient drug-free treatment is divided into the following different services:

- outpatient drug-free treatment which must be considered as drug-free post-treatment for drug addicts admitted for inpatient treatment;
- outpatient drug-free treatment targeted at a slightly younger, less addicted group;
- outpatient drug-free local treatment, including a combination of dedicated outpatient drug-free treatment and a special local flat-sharing scheme offered to a small group on the same drug-free treatment programme.

5.3.3 Dual diagnosis treatment

Mental disorders in drug addicts are a well-known phenomenon, given that drug use often appears together with actual mental illness or mental problems in the form, for example, of panic reactions, anxiety attacks, depressions and personality disturbances.

The prevalence of drug addiction among patients in the psychiatric system is at least 20%. Approximately 10% of people in the drug treatment system suffer from severe psychosis, for example schizophrenia.

In 2006, a total of 3 849 people were admitted to psychiatric hospitals with a drug-related primary or secondary diagnosis (co-morbidity).

There are a few specific outpatient treatment programmes for patients with co-morbidity. The special outpatient units handling the treatment of drug users with severe psychiatric problems have a relatively low capacity. From summer 2006, an outreach psychosis team has been established in Copenhagen with capacity for 100 drug addicts with psychiatric disorders. The plan for this treatment programme is to co-operate closely with the district psychiatric service as well the drug treatment services.

5.3.4 In/outpatient

The patients in medical treatment for opioid addiction (substitution treatment) are mainly treated in outpatient settings in special municipal centres. About 10% of drug users admitted for treatment are in an inpatient treatment setting, either in the form of detoxification with a view to obtaining a drug-free status or in the form of stabilisation on medication assisted treatment with a view to harm reduction in long-term substitution treatment.

Treatment is normally provided as outpatient treatment, to which inpatient treatment may be added if there is the need for a change of environment and/or more intensive work. Treatment may be medically assisted and should always be accompanied by psychosocial counselling based on the social action plan. The care and socially oriented intervention targeted at the most addicted drug abusers, in particular, takes place more and more via drop-in centres.

5.3.5 Drug and/or alcohol and prescribed drugs

In general, co-addiction of prescribed drugs or alcohol in patients on medication assisted treatment for opioid addiction are treated in the same facilities.

5.3.6 Availability/link to somatic and psychiatric treatment

According to the guideline from the National Board of Health, the medical treatment of drug addiction consists of both the diagnosis and treatment of drug addiction and the diagnosis and treatment of psychiatric and somatic

co-morbidity related to drug addiction. The doctors responsible for drug addiction treatment can refer to the general practitioners and hospitals when needed.

5.3.7 Rehabilitation services linked to treatment

In accordance with Section 141 of the Social Services Act, the municipality is obliged to offer drug users a social action plan, with goals and strategies discussed together with the individual drug user as regards his/her future housing situation, financial situation and other situations in life. Thus, the local case handlers are those with the competence to initiate action in terms of social integration of the drug users in a number of areas.

5.3.8 Treatment of young people

The Social Services Act of May 2005 stipulates that in special cases, the Minister for Social Affairs (now the Minister for Welfare) is authorised to establish rules on the guarantee of social treatment for drug users under the age of 18 years. The Minister for Social Affairs issued a ministerial order on the conditions for applying for such treatment. The purpose of the law is for the municipality to immediately arrange for the young person to be admitted for treatment for drug addiction. Young people with serious drug use problems must be put on a treatment programme within 14 days of contact, in the same way as adult drug users are provided with social treatment.

Treatment programmes provided to vulnerable young people are normally outpatient programmes established close to the young person's address.

5.4 Gender issues

5.4.1 Pregnant women/families with small children

Pregnant women

According to the law-based guideline from the National Board of Health on pregnancy, pregnant women with drug abuse problems must be ensured special and intensive obstetric and social care with the aim of elimination or reduction of potential risks. The strategy is for an early as possible intervention and shared multidisciplinary care.

Pregnant women with opioid addiction, who want to continue their pregnancy, should be offered substitution treatment if detoxification is not realistic.Principles of opioid substitution in pregnancy are:

– the same criteria are used as for non-pregnant women;
– women who received medical treatment for opioid addiction (substitution treatment) before pregnancy should be maintained initially at their pre-pregnancy doses;

– pregnant women who have not been using methadone before pregnancy must be admitted to an (inpatient) obstetric specialist ward;
– substitution treatment should be continued until after birth.

Some obstetric wards have special teams (mid-wife, obstetrician) who collaborate with the drug addiction treatment system, general practitioners and the social system. A specialist obstetric care ward for drug-using pregnant women is situated in the capital, as is a specialist outpatient setting for pregnant drug users in the treatment system for drug addiction.

Families with small children

In the social reserve pool of funds settlement for 2007 it was decided to amend the law on retention of drug users receiving treatment, whereby the municipal board is obliged to ensure that pregnant drug users receiving inpatient treatment receive a contract on retention. This amendment came into force on 1 July 2007. As part of the agreement, it was also decided to set aside funds over a four-year period with the pooled amount being spent on intensified action in support of pregnant drug users. The funds will be granted to a number of municipalities in their work to establish projects with this purpose in mind. The pooled funds have been announced as funds open for application.

5.4.2 Other gender issues

Specific surveys conducted in 2006 attempted to identify the special conditions pertaining to women with regard to their treatment for addiction in Denmark. These are prospective surveys, which all cover in different ways both the effect of the treatment and the processes that led to the effect. These projects are based on both quantitative and qualitative data.

15-17-year-old girls receiving treatment for an addiction problem

The overall aim is to find out why 15-17-year-old girls start taking alcohol and drugs, and the problems associated with such use. The analysis will also look at the women who manage to overcome their addiction and the conditions associated with stopping.

Women, drug abuse and treatment, with particular focus on the women most affected, who are receiving outpatient addiction treatment, including with methadone

The overall aim of this project is to produce an overall picture of the knowledge, prospects and experience relating to the conditions specific to women who take drugs, their particular problems and treatment requirements.

Women receiving inpatient treatment for alcohol addiction and how they differ from men in terms of their path into and out of alcohol dependency

The purpose of this survey is to describe in more detail the conditions and terms for alcoholic women receiving treatment, which includes therefore a more detailed explanation about their path into and out of addiction and their persistence in their addiction.

How to reduce the incidence of women spontaneously stopping drug-free inpatient treatment, with particular focus on female drug addicts

The purpose of this project is to identify women at particular risk of dropping out of inpatient treatment earlier than planned, so that special measures can be taken to prevent these women from dropping out early.

Pregnant women after inpatient treatment for their alcohol and drug addiction

The purpose of this survey is to find out what happens to pregnant women during and after their addiction treatment.

5.5 Treatment within the criminal system

The national strategy concerning criminal drug users is based on treatment being administered by the social authorities to a large extent. Treatment initiatives launched by the Prison and Probation Service should primarily be motivating and uncover needs. However, where participation in such a programme may be difficult for safety reasons, the Prison and Probation Service should aim at providing relevant treatment during imprisonment. On 1 January 2007, the Prison and Probation Service was given a treatment guarantee in relation to the drug users who are considered eligible and motivated for treatment and who at the time of seeking treatment are facing three months estimated legal penalty as a minimum.

As part of the government's social reserve pooled funds settlement for 2006, the Prison and Probation Service was allocated resources for a number of initiatives, including setting up two new treatment units and a follow-up treatment unit in selected prisons, as well as a number of outreach initiatives relating to drug users in prisons across the country. This is a wide-ranging initiative intended for inmates wishing to become totally "clean" and those preferring substitution treatment, mainly with methadone.

These initiatives have been implemented in accordance with the political intention of the settlement. At present it appears that the inmates have welcomed the new treatment programmes, given the relatively high number of people seeking treatment.

To improve the transition between a stay in prison and subsequent release, the Ministry of Social Affairs (now the Ministry of Welfare) issued a set of guidelines in 1998 in relation to co-operation between social services and the Prison and Probation Service's institutions and departments. However, this co-operation has rarely ever worked at all well, even though the need for co-ordination is great. Implementing measures, including treatment cycles, goes completely by the wayside if there is no handover on release (Ramsbøl, 2003). In February 2006, the Ministry of Social Affairs issued Ministerial Order No. 81 concerning the municipalities' duty to co-ordinate action plans with the Probation and Prison Service for certain groups of people. According to this order, the Prison and Probation Service must contact the municipality four weeks before a person is released in order to co-ordinate action plans, and the municipality is responsible for following up on the referral.

It has turned out to be difficult to establish co-operation between the municipalities and the Prison and Probation Service. This is mainly attributable to factors such as structural changes as a result of regional reform. The Ministry of Welfare and the Directorate of the Prison and Probation Service will in future focus on co-ordinating the action plans with a view to improving quality.

To support the implementation of both the new and older legislation, in 2006, the Ministry of Social Affairs, Ministry of Employment and the Directorate of the Prison and Probation Service jointly set up a three-year project intended to develop, test and describe the methods for handling this cohort of individuals properly on their release. There are three prisons, a number of municipalities, departments from the Prison and Probation Service and addiction centres involved in the project and these are some of the key players in terms of co-ordinating this measure.

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Norway

1 Demography

The population of Norway is almost 5 million people and the area is 324 000 square kilometres. The capital is Oslo with 550 000 inhabitants. Other major cities are Bergen (250 000), Trondheim (150 000) and Stavanger (100 000). Norway is not a part of the European Union, but participates in the European Economic Area.

2 Epidemiology of drug use

Two surveys on drug use among young people in 2006, both conducted in the same manner, one among the 15-20 age-group and one among young adults aged 21-30, showed major differences. The levels of drug use for 21-30 year-olds were more than twice as high as for the 15-20 year-olds, both in Norway as a whole and in Oslo. For cannabis, the experimentation is most frequent from the late teenage years and into the 20s and the data show a high degree of stability. The percentage of 15-20 year-olds having ever used cannabis was 13%, whereas 34% of the 21-30 year-olds reported cannabis use.

For other drugs, the trends are more unclear. For people under 20 years old, lifetime prevalence of amphetamine, cocaine and ecstasy declined between 1998 and 2006. For young adults, 21-30 years of age, the lifetime prevalence for all three drugs has increased considerably. Cocaine was reported to have been used by 2.2% (3.5% in 1998) of the 15-20 year-olds in 2006, while 9% (3% in 1998) of the 21-30 year-olds reported the same. Concerning amphetamine, 3.1% (3.5% in 1998) of the 15-20 year-old age-group reported use, compared to 9% (5% in 1998) of the 21-30 year-old age-group. The National Institute for Drug and Alcohol Research (SIRUS) estimated in 2005 that there were between 8 200 and 12 500 injecting drug users in Norway. The estimation for high alcohol consumption from SIRUS the same year was between 66 000 and 122 000 people in Norway.

The number of HIV cases among injecting drug users remains low, and the yearly incidence has been low for the last 15 years. The prevalence rate even in the most affected groups in Oslo is less than 5%. The testing rate is high and there are very few undetected cases when Aids is diagnosed. There has been a hepatitis B outbreak among injecting drug users in the last few years. During the period 1995-2006, the total number of reported cases of acute hepatitis B among drug users was 1 812. The infection rate of hepatitis C in injecting drug users is high, ranging from 60% to 90% prevalence in different tested populations throughout the country. The degree of co-morbidity

both concerning somatic and psychiatric illness is high among drug and alcohol dependent patients.

Drug overdose deaths rose from the mid-1990s until 2001 (338 people that year), but thereafter there has been a decline. In 2006, 195 people died as a result of opiate overdose in Norway, a figure which is still far too high.

In 2006, the highest number of cases and seizures of drugs for four years was registered. The trend is especially high for methamphetamine, cannabis and cocaine. The number of heroin seizures in 2006 was, however, the lowest for 15 years, and the number has been more than halved since 2001.

Data on patients entering treatment is collected nationally (by the Bergen clinics) and the 2006 figures show 21 987 admissions. Of the patients, 70% were men and 77% were neither in employment or in education. Alcohol was reported as the mostly used intoxicant by 44%, followed by 24% reporting heroin, 11% prescribed drugs, 10% stimulants and 9% cannabis.

3 Short history of drug treatment

Specialised drug treatment started in Norway in 1961 at a medical institution, patients mainly being health care professionals and restaurant employees. With the "modern" drug epidemic in the late 1960s, the institution clearly proved inadequate. During the 1970s and well into the 1980s Norway chose a model for drug treatment in collectives and therapeutic communities based on "community as method" and vocational training. Medical treatment and the disease model for addiction were to a large extent rejected. The treatment was organised within the social welfare system. With the advent of HIV in the mid-1980s, the Norwegian Government gradually reconsidered the refusal of medication assisted treatment (MAT) for opioid dependent patients. Starting on a small scale in 1991, MAT became nationally available from 1998. With the Drug and Alcohol Treatment Reform of 2004 (see below), the responsibility for the treatment of drug using patients once again became the responsibility of the health care services.

4 Organisation of treatment services

The treatment system for drug users in Norway has since 1 January 2004 been a part of the general health care system. The Drug and Alcohol Treatment Reform that passed as a law amendment in the Norwegian Parliament the previous year gave the responsibility for interdisciplinary specialised treatment to the regional health authorities. The drug reform laid the organisational foundation for expansion and improvement of the specialised services for patients with substance abuse problems. The introduction of patients' rights in the drug reform was an important step towards improving the treatment of substance abusing patients. The focus has increasingly been put on users' involvement in the treatment process both on an individual

and a general level. The drug reform has been evaluated as successful as far as organisation is concerned, but is lacking both in quantity and quality of the treatment offered.

The specialised treatment service for drug and alcohol using patients is called interdisciplinary specialised treatment, indicating the necessity for the involvement of different health and social welfare system professionals in the treatment, even though the treatment is organised under the health care system.

The government has been giving priority to drug treatment and psychiatric treatment in the budgets for hospital funding over the last three years. There has been a general expansion in the treatment capacity for interdisciplinary specialised treatment since 2004, but there are still too few treatment slots both for in- and outpatient treatment. In April 2007, there were 439 people on the waiting list for MAT and 3 655 people on the waiting list for other alcohol and drug treatment. The average waiting time to get into treatment was 70 days.

In the municipalities the social welfare system has the main responsibility for follow-up of drug users. With the drug reform, general practitioners have been given a more important role in drug treatment than previously. The continuity of services and co-operation between the social welfare system, the general practitioners and the specialised treatment system has always been and still is one of the greatest challenges in drug treatment systems.

In October 2007, as part of its budget proposal, the government presented an action plan for the drug and alcohol field. The plan ranges from prevention to treatment and rehabilitation. The aim of the plan is to have a policy with a clear public health perspective. The aim is also to raise professional standards through research and through strengthening competence and quality. The five main goals of the action plan are:

1. a clear public health perspective;
2. better quality and increased competence;
3. more accessible services and increased social inclusion;
4. binding co-operation;
5. increased user influence and greater attention to the interest of children and family members.

5 Services

There were 1 800 slots for inpatient treatment of drug and alcohol users in Norway in 2006, approximately equally divided between short-term treatment (less than six months) and long-term treatment. The treatment system is organised within the health care system and consists of both public and private institutions (financed by the state through contracts).

Referral to drug treatment is performed either by the general practitioners or by the social welfare system. The referrals have to be dealt with by the interdisciplinary specialised treatment system within 30 days (stated in the patients' rights law) and the patient is then given a time limit for when treatment has to be given based on what is justifiable according to his or her condition.

The treatment clinics have different treatment modalities, amongst them 12-step treatment programmes, collectives, therapeutic communities and more traditional treatment clinics. Most of the treatment services are both for alcohol and drug using patients, including patients dependent on prescribed drugs.

Most regions in Norway offer detoxification for drug users. Detoxification is mainly performed prior to planning of treatment or longer-term treatment and most often it is performed as inpatient treatment.

Norway has, since the mid-1980s, had quite a lot of inpatient treatment for drug users, compared to many other western countries. Lately there has been a debate amongst professionals and between administrators and professionals on how large a part the inpatient services should be of the total treatment services for drug users.

5.1 Detoxification

Most regions in Norway offer detoxification for drug users. Detoxification is mainly performed prior to planning of treatment or longer-term treatment, most often inpatient.

5.2 Evaluation/planning of treatment

The planning of the treatment is often performed in an outpatient setting, if possible, or as part of a detoxification stay. The purpose is to diagnose the patient's problems and resources and evaluate what kind of treatment the patient is in need of.

5.3 Treatment

5.3.1 Substitution treatment

The MAT was offered on a national basis in 1998 and expansion has been quite rapid, with approximately 500 new patients each year. The treatment is commissioned by regional centres, but the treatment is a co-operation between the specialist clinics, the general practitioners and the social welfare system.

There were approximately 4 700 patients in MAT in Norway at the end of April 2008, using methadone or buprenorphine. The average age of patients is 40.1 years and 30.5% of the patients are women. Of these patients 39% are

being treated with buprenorphine and 61% with methadone. The average methadone dosage is 109 milligrams and the average dose of buprenorphine is 18.6 milligrams.

Of the patients 14.3% reported using opiates the previous month, 42.3% had used benzodiazepines and 33% cannabis. It was reported that 65% get their prescription from general practitioners, 49% get their medication from pharmacies and on average 1.5 urine samples are taken for each patient every week. The figures refer to the whole MAT population in 2007, reported for 78% of the patients (Norwegian Centre for Addiction Research, 2008).

5.3.2 Drug-free treatment

Most of the treatment services are available for patients both as drug-free treatment and as substitution treatment. This has been a clear objective of the policy makers, to try to avoid the polarisation of the two treatment modalities. Only a few inpatient services are only available for patients in drug-free treatment.

5.3.3 Dual diagnosis treatment

There is increasing attention in mental health treatment programmes and in the drug treatment system that a high percentage of the patients in these treatment systems have both a serious drug problem and a mental disease. The patients with dual diagnosis generally are in need of long-lasting, individually tailored treatment consisting of services from different parts of the health and social services. In the last decade several new dual diagnosis treatment units have been established. More mobile teams have also been organised, in order to make contact with these patients and improve the follow-up. The evaluation of the Drug and Alcohol Treatment Reform pointed out that co-operation concerning patients with co-morbidity seems to have improved, but there is still a long way to go.

5.3.4 In/outpatient treatment

Norway has, since the mid-1980s, had quite a lot of inpatient treatment for drug users, compared to many other western countries. Drug users have stayed at the institutions for up to three years. Lately there has been a debate amongst professionals and between administrators and professionals on how large a part inpatient services should be of the total treatment services for drug users. The object for the government is to find a flexible way of using the in- and outpatient treatment slots most efficiently.

5.3.5 Availability of somatic and psychiatric treatment

The drug-using patients have been using somatic and psychiatric services for a long time. The HIV-epidemic made the drug treatment services and

infectious disease department co-operate closely, but co-operation with other somatic and psychiatric services has varied. One of the objects of the drug reform was to improve the availability of somatic and psychiatric treatment. This has happened to some extent, but there is still some way to go.

5.3.6 Rehabilitation services

There has always been an emphasis on the necessity to link treatment services and rehabilitation services in Norway. With the introduction of substitution treatment in Norway, this became even more obvious. The rehabilitation services are mostly linked to the social services, so there is a need for co-operation between the services. The rehabilitation services consist of housing programmes, vocational training and different forms of social training.

5.3.7 Treatment of young people

Younger drug users can be treated in the same outpatient clinics as older patients, but the treatment has to be adjusted to their particular needs. There has been an ongoing debate for some time as to whether it is correct to treat young drug abusers in the same inpatient setting as older patients. Some clinics for young people have been established in the last few years.

5.4 Gender issues

5.4.1 Treatment of pregnant women/families with small children

There is a national consensus that pregnant drug users should be given help to abstain from use of all illegal drugs and alcohol during pregnancy. The same applies to patients who have custody of their children. Outpatient services are usually available where the pregnant drug user will come into contact with the treatment system first. Primarily the ordinary drug treatment clinics will meet these patients, but the specialised clinics for pregnant women and families also have outpatient treatment facilities.

Drug-free treatment is in most instances the first treatment of choice, also for pregnant opioid users. If the pregnant woman continues using drugs, action will normally be taken to refer her to compulsory treatment. The services for inpatient treatment of pregnant drug users are well organised. There are several treatment institutions in Norway which have specialised treatment programmes for pregnant drug users and drug users with children. The patients can stay at the clinic for the whole pregnancy and often after birth together with the baby as well.

Approximately 160 women have given birth while being on MAT in Norway from 1996 until today. In principle, family planning is part of the MAT programme and pregnancies are discouraged for unstable patients. Thorough information is given to pregnant women/couples and alternatives

are discussed. The current policy is that methadone or buprenorphine should be continued throughout pregnancy with the lowest efficient dose of the medication administered. As part of ordinary MAT treatment, groups for counselling/co-ordination of services are organised around each individual MAT patient. This group will be supplemented when a patient becomes pregnant.

Stopping substitution medication is unrealistic for most women, but reducing the medication gradually should be discussed with all stable patients. For most patients it is recommended to reduce medication to some extent and this should take place between week 14 and week 36 of the pregnancy. The families need long-term multidisciplinary follow-up.

5.4.2 Other gender issues

Detention of alcoholics or drug addicts comes under the Norwegian Social Services Act, sections 6-2 to 6-3. There are three statutes in the Norwegian Social Services Act that regulate this subject matter. Section 6-2 permits compulsory admission to institutions for a period not exceeding three months for a person who might jeopardise his/her physical or mental health through extensive and persistent alcohol or drug abuse. Section 6-2a allows pregnant alcoholics or drug addicts to be incarcerated if the abuse most certainly will damage the child. The maximum period of incarceration is the remaining time of the pregnancy. Section 6-3 regulates voluntary admission to an institution for alcoholics and drug addicts on the condition that the patient consents to being detained if he or she tries to leave the institution. The law amendment making it possible to treat drug users on a compulsory basis was put into action in 1994. The decision of compulsory admission according to sections 6-2 and 6-2a is made by the County Board for Social Cases. A number of institutions have been selected to treat patients according to these sections.

Norway passed a compulsory treatment act for pregnant drug users in 1996 (see above, concerning section 6-2a). The law has been used relatively sparingly and has not been systematically evaluated. Mainly drug users (not alcoholics) are treated on a compulsory basis. The patients tend to come into treatment relatively late in the pregnancy. The table below (Table 1) accounts for the number of cases which have been dealt with by the County Board for Social Cases each year. Temporary decisions can be taken by the social services alone but they are supposed to be the exception to the general law.

Table 1: Cases dealt with by the County Board for Social Cases

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Temporary	18	30	42	19	11	34	23	36	35	48
Ordinary	10	17	24	10	13	27	12	28	47	30

There will be an extensive national evaluation of the compulsory treatment act in 2008 and 2009, focusing on both the epidemiology, the legal issues including patients' rights, the content and duration of the stay, and the short- and long-term outcomes for the patients.

5.5 Treatment within the criminal justice system

It is reported that 60% of the prison population has problematic use of alcohol and/or drugs. There are 3 500 people in jail at any time in Norway and, in the course of a year, 13 000 people have been to prison for a shorter or longer time.

For many years it has been possible for prisoners to serve part of their sentence in a treatment institution and approximately 450 prisoners use the opportunity yearly. In the last few years several substance abuse units have also been established, with the possibility to continue treatment when the sentence is finished.

6 Special issues

The Ministry of Health and Care Services has commissioned the Directorate of Health to develop national guidelines for the treatment field. Presently, there are ongoing guideline processes for:

- medication assisted treatment (MAT);
- dual diagnosis;
- MAT and pregnancy and the follow-up of the children and families until the children reach school-age.

The plan is to cover the whole treatment field and thus have guidelines for all.

7 Strengths and weaknesses

The Norwegian treatment system for drug users is generally of high quality and the availability is good in most of the country, both concerning in- and outpatient's treatment slots, compared to most other western countries. The treatment modalities are quite varied, giving the patients quite a lot of options concerning the type of treatment to choose between.

There are still too few treatment slots for drug users in both outpatient and inpatient settings, especially in western and northern Norway. There is also too long a waiting period for treatment for most kinds of treatment in most parts of Norway. There is also a great variability in the kind of treatment offered in different regions of Norway.

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www.helsedir.no – Norwegian Directorate of Health
www.sirus.no – Norwegian Institute for Alcohol and Drug Research (SIRUS)
www.regjeringen.no/nb/dep/hod – Ministry of Health and Care Services

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Norwegian Directorate of Health
Norwegian Institute for Alcohol and Drug Research (SIRUS)
Ministry of Health and Care Services

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Sweden

1 Epidemiology of drug use

There are about 100 000 people with severe alcohol and/or drug abuse problems. 80 000 with alcohol abuse (the average age is 50 years, 25% women) and 26 000 with drug abuse (the average age is 38 years, 35% women).

There are almost 3 000 people in pharmaceutical-assisted treatment for drug abuse (methadone and buprenorphine (Subutex/Suboxone)).

On 1 November 2006 about 21 300 people were being treated within the social services for problems related to alcohol or drug abuse. The municipalities' costs for abuse care were 5 billion SEK in 2006.

2 Organisation of treatment services

The responsibilities of the municipal social services are regulated by the Social Services Act. According to the act, one of the responsibilities is to provide substance abuse care. Abuse requires extensive and varied efforts on the part of the community – from outreach and prevention to care, treatment and rehabilitation of people with serious problems.

The health care system also has a responsibility for substance abuse and dependence care. The medical services are responsible for medical treatment such as abstinence care and pharmaceutical-assisted treatment. Since 2006 legislation has been put in place for needle exchange programmes in Sweden. One county council has such a programme (Skåne region).

The National Board of Health and Welfare monitors the care of abusers within the health care system and compiles information about the county councils' monitoring of abuse care within the social service system. The board are also working with guidelines, quality indicators and the gathering of know-how related to substance abuse care.

The National Board of Institutional Care (SiS) is responsible for the care that takes place without the consent of the individual (Compulsory Care of Alcohol and Drug Abusers Act – LVM care). SiS has 47 LVM homes and special approved homes in various parts of Sweden. Most substance abusers in SiS institutions have been placed there without their consent because they are in danger of injuring themselves or of ruining their lives.

Abuse care is also offered to clients within the prison and probation service.

3 Services

A strategy to develop misuse treatment in Sweden in 2008-2010 has been drawn up. The aims are to improve quality of care and treatment, secure equality and raise awareness of the needs of vulnerable groups such as pregnant women, children living in families with substance abuse and people with mental illness and misuse problems.

In 2007 the National Board of Health and Welfare published treatment guidelines for misuse and dependency care and an implementation guide. The guidelines are based on reviews on existing knowledge. A large number of referral bodies, including a large number of organisations of service users were given an opportunity to present their views.

Practitioners within the social services and health care sector have shown a great interest in these guidelines. A survey shows that almost all practitioners know about the guidelines but very few have started to implement them. The government made an agreement with the Swedish Association of Local Authorities and Regions (SALAR) which aims at giving them a leading role in implementing these guidelines. The government has allocated 28 million SEK for this agreement which shall be used to develop a regional structure for knowledge development and support. Scientific evaluation will be made both regarding outcomes related to the quality of treatment and also the implementation process.

Attention has been drawn to the fact that there are unacceptable differences between municipalities and regions in Sweden regarding access and quality of misuse care. The government has therefore strengthened the monitoring of both the municipalities and the county councils. The county administrative boards and the National Board of Health and Welfare have been appointed to strengthen the monitoring of all institutions that give drug misuse care and also to make the users more involved in the monitoring process. The monitoring also aims to promote the implementation of the national guidelines.

To ensure that people with drug misuse problems get adequate care, the government has decided to make a thorough review of the legislation regulating the substance misuse care and the responsibility of different bodies. A report will be tabled in November 2010.

During the period 2005-2007 the government invested a total of 820 million SEK to encourage municipalities and other actors to develop and strengthen the care of substance abusers. Of this sum, 120 million SEK was earmarked for initiatives in the prison and probation service. A total of 400 million SEK has been earmarked as direct support for the municipalities in developing specialised and integrated care of substance abusers, introducing a guarantee of treatment for quicker initiatives and developing individual care plans. To

strengthen the care that takes place without the consent of the individual (LVM care), the government has earmarked a sum of 300 million SEK.

The Office of National Drug Policy Co-ordination (Mobilisering mot narkotika) and the former psychiatry co-ordinator have jointly presented a ten-point programme for the care of people who have a mental illness/disability and are also substance abusers. The programme was distributed to all the municipalities and county councils during the autumn of 2005.

Centre and east of Europe

Bulgaria

1 Organisation of treatment services

A network of treatment centres and treatment programmes, which is in the process of development and enlargement, has been built up in the country. The total number of beds for addiction treatment at the institutions for inpatient help is 641 419 in state psychiatric hospitals, 119 in units of other hospitals for active treatment, and 103 in regional dispensaries for psychiatric diseases within hospitals.

Treatment institutions in the country work with different programmes for detoxification (treatment of withdrawal syndrome), "daily care" substitution and rehabilitation programmes, psychotherapeutic family therapy, and others.

Medical urgent care centres (MUCCs) are responsible for treatment in emergencies, where, if necessary, patients are referred to units for toxicology and intensive treatment or to other hospital units.

2 Services

2.1 Substitution and maintenance treatment:

On 31 December 2007, there were 17 substitution and maintenance programmes with 2 910 places in total, 2 405 for treatment with methadone hydrochloride and 505 for treatment with morphine sulphate pentahydrate (Substitol). The number of places for treatment in substitution and maintenance programmes has doubled compared to 2006.

Programmes work on the basis of permission from the Minister for Health, according to Regulation No. 24 (2000), on the way to implement substitution and maintenance programmes in order to reduce health problems in drug addicted individuals.

Programmes are long term, high threshold and highly structured. They are intended to affect all the spheres of the personality and include modules for individual and group consultation and more intensive and systematic psychotherapeutic work. They also involve the family of the patients. The average number of patients included in this systematic and long-term psychotherapeutic process varies from 10% to 30%.

Psychiatrists, internists, secondary medical personnel, psychologists and social workers take part in the programmes, and this allows for more varied interventions, including psychosocial ones.

The treatment process is based on the "phases of treatment"[2] model, the essence of which is based on the understanding that addiction is a chronic recurrent disease and patients with opium addiction need long-term treatment, structured in the following phases:

1. intensive stabilisation phase;
2. binding and rehabilitation phase;
3. medical maintenance phase;
4. methadone detoxification phase;
5. zero dose phase.

The main aims of the programmes for methadone substitution maintenance treatment are to:

– reduce addiction severity;
– achieve and maintain an optimal level of medical and social functioning;
– restrict criminal behaviour related to drug addiction;
– preserve public health by confining the risk of HIV/Aids, hepatitis and other blood-borne transmissible infections.

Drug addicted patients in substitution and maintenance programmes are treated with methadone hydrochloride and morphine sulphate pentahydrate (Substitol).

Patients with medical indications, for example those who are pregnant, HIV-positive or in the acute phase of hepatitis B or C, have priority admission into the programmes. Psychiatric co-morbidity states are assessed individually.

Ten programmes for field work, exchange of needles and syringes, and testing for blood and sexually transmissible infections started to function in 2007 within the framework of the Prevention and Control of HIV/Aids, Malaria and Tuberculosis Programme of the Ministry of Health, financed by the Global Fund, under Component 4: "HIV prevention among intravenous drug addicts".

Mobile consulting rooms are maintained by seven non-governmental organisations in the cities of Sofia, Bourgas, Varna, and Plovdiv.

2.2 Rehabilitation programmes

Rehabilitation and re-socialisation of drug addicted individuals is carried out in seven rehabilitation programmes, situated in Sofia City, Sofia region and Varna, with a total capacity of 125 places. Day care centres are the effective form of organisation for outpatient treatment for addictions. Five of these

2. Structured and described by Moolchan and Hoffman.

day care rehabilitation programmes function in the country, four in Sofia and one in Varna.

The opening of protected homes for patients who have successfully passed through inpatient programmes for addiction treatment is an element in the development of the contemporary system for treatment and rehabilitation in Bulgaria.

Therapeutic communities (communes) are a form of long-term residential treatment and rehabilitation. Two long-term rehabilitation programmes of this type with a total capacity of 50 places are now functioning:

– "Phoenix House" is a long-term rehabilitation programme in the village of Brakjovtsi, municipality of Godech, Sofia region, with a capacity of 30 places;
– the "New Beginning Home" is a rehabilitation centre for drug addicted individuals in the village of Bunovo, municipality of Mirkovo, Sofia region, with a capacity of 20 places.

Within the national employment plan of 2007, a national programme for the employment and professional education of people with lifelong disabilities has been approved, and this also includes unemployed people who have successfully undergone a course of treatment for drug addiction. The main aim of the programme is to increase employment prospects and to provide employment for people from that group, as a prerequisite to overcoming their social isolation and to facilitate their reintegration into society.

The national centre for addictions works in close collaboration with treatment and rehabilitation programmes in the country in order to raise awareness among those who have successfully undertaken a course of treatment for drug addiction, regarding the possibilities to enter the programme.

2.3 Evaluation and monitoring

In order to improve access to treatment programmes, an Information Consultative Centre provides free consultations and information for addicted people and their relatives on the possibilities for detoxification, treatment, rehabilitation and social reintegration. The centre opened in the National Centre for Addictions in November 2007.

The main activities that are performed in the Information Consultative Centre include:

– evaluation of addiction severity;
– evaluation of concomitant problems;
– informing clients about the programmes for consultation, treatment and rehabilitation in the country;

- enabling addicted people and their parents and relatives to seek treatment;
- preparation and motivation to enter long-term treatment programmes;
- inclusion of parents and relatives in the treatment process;
- helping various services, programmes and teams to build up a network.

With a view to improving co-ordination among various treatment programmes and to have information available on the treatment services, the following registers have been developed and are maintained in the National Centre for Addictions:

- a register of treatment institutions which implement substitution and maintenance programmes for drug addicted individuals;
- a register of people who implement pre-treatment and rehabilitation programmes;
- a general national register of patients participating in substitution and maintenance programmes for drug addicted individuals.

Croatia

1 Demography

Croatia, officially the Republic of Croatia, is a country located in south-central Europe at the crossroads of the Mediterranean, central Europe and the Balkans. Croatia has an area of 56 594 square kilometres (plus a sea area of 31 067 square kilometres), 1 777 kilometres of coastline and more than 4 000 kilometres of island coastline. The Croatian population is 4 442 000[3] inhabitants: 2 138 700 men and 2 303 300 women. The capital city is Zagreb which has 779 145 inhabitants. In relation to the age structure, 16% are 0-14 year-olds, 67.1% are between 15 and 64 years old and 16.9% are 65 years old and over. Population density at the national level is 78.5 inhabitants per square kilometre.

2 Epidemiology of drug use

At the end of 2006, a total of some 23 990 people were registered as receiving treatment for psychoactive drug misuse, according to the Register of the Croatian National Institute of Public Health which keeps records of all the addicts in Croatia treated for drug misuse, as well as of the causes of death of drug addicts. It is a disturbing fact that the total number of new addicts registered in the inpatient and outpatient treatment system has been continuously increasing in the period 2000 to 2006. According to the Croatian National Institute of Public Health, in 2006 there were 7 427 treated drug addicts (248.1 per 100 000 inhabitants, aged 15-64), which represents an increase of 11.38%. Of the total number of those treated, the majority were opiate addicts (5 611), 2 001 were new in treatment and of these 876 were new opiate addicts. The total number of people in Croatia hospitalised for addiction was 1 142 and the length of time spent in hospital was, on average, 30.2 days. The larger number of treated addicts may be the result of an increasingly stable network of centres for the prevention of addiction, as well as the result of more addicts participating in some form of treatment.

According to the number of treated people per 100 000 of active age (aged 15-64), the County of Istria was ranked first (747 people, 525.5 per 100 000 of active age), the County of Zadar was second (522 people, 491.8 per 100 000), the City of Zagreb was third (2 365 people, 440.4 per 100 000) and the County of Šibenik-Knin was fourth (266 people, 373.6 per 100 000), while the average rate for Croatia was 248.1 per 100 000 inhabitants, aged 15-64. Experts believe that the increase in the number of drug addicts in Croatia is

3. 2005 mid-year estimate of the Central Bureau of Statistics.

primarily the result of negative social factors, such as the difficult economic situation, the war, the increase in crime, easy access to drugs or population migrations.

In Croatia, the average age for first time experimentation with drugs is 15.9, while the average age of heroin first use is 20.0. The average age for intravenous use is 20.8 and 25.5 is the average age for entering treatment, therefore 10 years after first experimenting with drugs. The majority of addicts (2 031 or 27.3%) are between 25 and 29 years of age. With respect to gender, 6 127 men and 1 300 women received treatment in 2006. The tendency of addicts to be primarily male still continues. The majority of treated addicts were narcotic addicts (5 611 or 75.5%) and this represents an increase compared to previous years. There were 1 071 people (14.4%) treated for cannabis addiction. The use of cannabis is the most widespread among young people under the age of 19. The number of people treated for cocaine addiction, which is the most common, has slightly increased (1.5%) when compared with 0.9% in the previous year.

In substitution therapy, methadone was used in the treatment of 2 776 narcotic addicts (48.4%), while buprenorphine was used in 505 cases (8.8%) which is significantly more than the year before. The most common means of treatment of addicts who took non-narcotics is counselling, guidance and support (68.6%).

Of the total number of 1 174 people who were treated in clinics in 2006, 757 had an accompanying diagnosis (64.5%), 447 of them were treated for opiate addiction and 310 for use of other substances. Among the treated opiate users, the ones with a registered specific personality disorder make up the largest number (181 people, 40.5%), followed by alcoholism (10.5%), chronic hepatitis C (8.3%), depression (8.1%) and others. Psychiatric disorders such as schizophrenia were registered among 19 people (4.3%), and there were also cases of acute and transient psychotic disorder (2.0%) and psychosis (1.3%). Accompanying psychiatric diagnoses have been registered more and more frequently. A specific personality disorder was registered for 13.8% of opiate addicts in 2003, 24.6% in 2005 and it almost doubled in 2006. The need to pay more attention to the existence of dual disorders and diseases, which require specific treatment approaches and comprehensive care, conforms with the results of various international studies and clinical reports.

An accompanying diagnosis was established in 310 cases of non-opiate users. The accompanying diagnosis rate among the people treated for non-opiate use is slightly lower, but, as with opiate users, specific personality disorder (22.3%) was the most prominent. Alcoholism (14.5%), again similar to opiates, is the next most common accompanying diagnosis, followed by acute and transient psychotic disorders (9.4%). The schizophrenia rate for non-opiate users is higher than the opiates rate and it amounted to 8.4%.

Psychoactive drug addicts are, due to the nature of their illness, exposed to a risk of blood transmitted diseases. According to the data obtained in interviews, most of the heroin addicts are infected with hepatitis C and in 2006 the rate was 46.2%. A smaller number of people were positive for hepatitis B (15.5%). Since only some of the data corroborated the laboratory test results, it may be suggested that the number of people infected is higher. The HIV data are the only ones checked and compared in a number of different ways and thus the low incidence of HIV infection among the addict population can be considered a true estimate. The incidence of HIV-positive individuals has not changed for a number of years now. The number of HIV-positive addicts is very low and amounts to 0.5%. This in turn is due to permanent education programmes leading to people being well-informed, pharmacotherapy, counselling centres and replacement needles and syringes.

The risk behaviour of drug users includes all the behaviours which could possibly expose them to accompanying diseases and complications. What is especially relevant is the use of common needles, syringes and other accessories as well as other risk behaviour. Whereas there is no routine information on use or non-use of barrier contraception (condoms), drug users are asked whether they are sharing needles and syringes at each visit to a centre. Although around 70% of heroin addicts have shared accessories at least once in their lives, a decrease in such risky behaviour has been observed. In the last month of 2002, accessories were shared by 38.6% of drug users and in 2006 this had decreased to 21.6%. The opening of centres for replacement needles and syringes, counselling and free testing for hepatitis B, C and HIV have contributed to more responsible behaviour by drug addicts and better co-operation.

In the year 2006, 94 people died from drug-related causes or who had been previously treated for drug addiction. Of these, 84 were men (89.4%) and 10 were women (10.6%). The largest number of them used opiates (84 people, 89%). The most common cause of death was opiate overdose (65 people, 69%), 32 of them overdosed on heroin (34.0%), 18 on methadone (19.2%), and for 15 people (16.0%) it was not notified which opiate substance was the cause of death. There were 9 deaths from other diseases, such as hepatitis C, intracerebral haemorrhage, asthma, uraemia, lung oedema and others. The largest number of people who died, as in previous years, resided in the City of Zagreb (34 people, 37.8%), followed by the County of Split and Dalmatia (17, 18.9%) and finally the County of Istria (9, 10.0%).

3 Short history of drug treatment

In the Republic of Croatia methadone therapy in the treatment of heroin addiction was implemented at the beginning of the 1990s when, due to the war years, the outbreak of an epidemic among drug users was predicted. Thus methadone therapy was introduced to prevent an outbreak of HIV,

hepatitis B and hepatitis C epidemics, as well as to reduce the potential criminal activities of these patients. Furthermore, considering the resources available for the treatment of drug users during this period and the increased number of drug users, it was almost impossible for all of them to receive some kind of drug-free treatment. In parallel, strong prevention activities were initiated.

The first National Drugs Strategy was adopted by the Croatian Parliament in 1996, setting an organisational framework for the national system on combating narcotic drugs abuse.

4 Organisation of treatment services

In Croatia, treatment of drug addicts is organised within the national health system, while certain measures of treatment and rehabilitation are also provided outside the health system.

In the Republic of Croatia there are institutions specialised in inpatient and outpatient treatment of drug users:

– inpatient treatment: five psychiatric hospitals, one ward in a clinic, one ward in a general hospital and one in a prison hospital;
– outpatient treatment: provided in the services for addiction prevention (in 2006 there were 21 such services in the Republic of Croatia);
– rehabilitation programmes: implemented in therapeutic communities.

4.1 Ministry of Health and Social Welfare

The general health system in Croatia is under the supervision of the Ministry of Health and Social Welfare, which also covers all state institutions involved in the treatment of drug addiction as part of health care.

In the area of inpatient treatment, psychiatrists and psychiatric institutions play a particularly important role. According to the National Drugs Strategy, clinics or general hospitals in bigger cities have to provide facilities for addicts' detoxification, with an estimated one-month average stay. After detoxification, further outpatient treatment should follow. In the first phase of the development of the programme network, the total number of 50 beds should be available in the psychiatric sector for the process of detoxification. The ward for treating the most severe addicts has to be open. It is not necessarily oriented toward detoxification, but towards a stabilisation of the addicts' general condition. This is where the addicts in a critical condition after attempted suicide or overdosing should be treated, so that optimal pharmacotherapy can be prescribed. In order to be able to monitor those who want drug-free withdrawal, especially those with court orders

for compulsory treatment, another 40-60 beds should be provided for the continuation of their hospital treatment within a therapeutic community lasting for two to three months. At least 10 beds of this number should be assigned to a specialised hospital programme for minor addicts. A smaller number of addicts should be accepted by all psychiatric institutions as part of their obligations in the case of emergency situations and patients with severe psychiatric diseases (e.g. psychosis or suicide propensity).

A family doctor actively participates in planning adequate intervention for every individual drug addict; they arrange with the centre the types of treatment, co-operation and control of the condition of each individual. The doctor also provides the medication indicated by a specialist and is responsible for daily control of the addict's health and the regular taking of prescribed medication. The doctor integrates other diagnostic and therapeutic activities regarding the patient's general health care requirements and undertakes prevention activities regarding blood-transmitted diseases. This is of great importance for an addict and their family (including testing and preventive vaccination of addicts and their families/household). The family doctor also investigates other potential issues within the family which may pose a risk of disease occurrence. They must also co-ordinate the work of various services that jointly care for the individual and family and/or provide complex health-rehabilitation treatment. Based on the monitoring of the course of treatment they may also suggest other services that may eventually need to be used.

4.2 Croatian Institute of Public Health

In accordance with the legal regulations and the system for addiction prevention and outpatient treatment, the Croatian Institute of Public Health is the central institution for the co-ordination and monitoring of addiction problems. This is conducted through the Croatian Institute of Public Health's participation in designing the addiction treatment doctrine and controlling its application. Other tasks for the Institute of Public Health include monitoring and registering people treated within the health care system according to all relevant factors, keeping up to date the Croatian Registry of Treated Psychoactive Drug Abusers and jointly co-ordinating and controlling the counties' addiction prevention and outpatient treatment centres. The Institute of Public Health co-ordinates special programmes and measures to combat and prevent addiction diseases, to plan and participate in the implementation of health care education and to provide meaningful information to the population. The Institute of Public Health is also responsible for the organisation and participation of health care workers and their permanent education, advisory and educational work with school employees, participation in special programmes on health and their promotion and

other functions such as co-operation with the media with the purpose of fighting addiction.

4.2.1 Services for drug addiction prevention

These are organised within the county institutes of public health, under the supervision of the Croatian national Institute of Public Health. In these centres professional interdisciplinary teams work together. They are responsible for the majority of specific activities oriented toward drug demand reduction and treatment implementation planning.

The principle tasks of these services are as follows:

– outpatient therapeutic work with drug addicts and their families carried out in co-operation with all relevant resources of the local community; the centre is the place of primary, specialised, health and psychosocial care of people with drug addiction problems;
– direct promotion and implementation of a range of preventive activities, especially early secondary prevention measures;
– epidemiological monitoring, co-ordination and implementation of drug consumption reduction programmes within the territory of the particular centre.

In the course of outpatient addiction treatment, the centres are the places where addicts for the first time get in touch with specialised workers. These workers carry out diagnostics in accordance with the clinical picture and suggest potential treatment. The addicts' treatment is carried out in co-operation with the teams of family physicians, with specialised hospital programmes and other health and non-health input. The centres, in co-operation with family physicians and the chemists' (pharmacists') network, supervise the pharmacotherapy of opiate agonists and antagonists in the area. The centres organise abstinence psychotherapy, education and monitoring of the heroin addicts included in the treatment programmes and also initial acceptance of addicts who have completed inpatient treatment (hospitals, prisons, communes, detoxification units, etc.). In big cities and tourist resorts these centres can establish independent units for direct implementation of substitution programmes for travellers, tourists and, temporarily, for the addicts who do not have health insurance, have not chosen a general physician or who are repeatedly aggressive and unco-operative.

Apart from direct participation in treatment, the centres have other specific tasks: organising and carrying out specific individual counselling for young people and families with a high risk of drug use, and providing assistance to educational institutions in the area concerned through the implementation of preventive programmes in the educational system. These centres offer specific training for professional workers within the educational system. Furthermore, they offer activities for high-risk groups of children and

young people together with professional services within the educational institutions. Such centres co-operate with school medicine advisory centres and, if required, with social security centres, jointly co-ordinating the implementation of all preventive activities aimed at risk reduction of HIV-infection and hepatitis (counselling and motivation for HIV and hepatitis B and C testing). These centres can keep open telephone lines for parents, drug users and drug addicts; they can participate in education and direct co-operation with outreach workers who work directly "in the field". The centre's professionals can perform the jobs of court expert evaluation when ordered by the authorised court, go to hearings and give expert opinions. The centres also participate in organising and implementing drug addict treatments in correctional facilities in co-operation with health care and other workers, as well as in implementing measures of compulsory addiction treatment ordered by the authorised court. Together with other services of the Institute of Public Health, the centres establish communication with the media in prevention campaigns, organise and participate in training the volunteers and workers in different occupations, and provide professional help in establishing citizens' associations and in the development of the network of clubs for treated addicts.

4.2.2 Tasks of other health care professions and institutions

Tasks of the school-based health care

A school doctor in the county Institute of Public Health should encourage local schools to promote the drug use control programmes as prescribed.

Teams should be created, comprising school doctors, class teachers, professional school advisers, the head of the preventive programme and, if needed, associates from the social security centre. Such teams are expected to participate in the process of identifying schoolchildren at extremely high risk of developing any kind of psychic or behavioural disorder, or of drug usage at an early age. For these children, special and additional protection measures are provided.

In places which are quite a long way away from the nearest addiction prevention centre, a school doctor, through their advisory work, will provide the necessary therapeutic procedures for younger drug users.

School-based health care will ensure a way of integrating drop-out students, such as those expelled, into the health care system. General practitioners, school doctors and county joint co-ordinators, together with local non-governmental organisations and social security centres, participate in the organisation and implementation of these special protection programmes.

Tasks of gynaecologists and obstetricians

A pregnant drug addict has to be admitted to a hospital institution. Due to the specificity of the problem, counselling with the professionals workingin addiction centres is required, especially if it is a question of addiction treatment of both the patient herself and the infant after birth.

Specialised programmes for pregnant addicts should be provided. For heroin addiction, withdrawal during pregnancy is not recommended but prescription of opiate agonists. The treatment of the baby, in case of abstention syndrome, will be performed by neonatologists, if required.

Tasks of paediatricians

When providing health care for young adolescents, paediatricians have to check for the potential for drug abuse, especially in cases of intoxication or after attempted suicide. Whenever the signs of disturbed behaviour or sudden neglect in performing school duties are noticed, the schools are obliged to act in a preventive way, to prevent drug use. Where there is doubt, counselling with a school doctor and other professionals from the addiction centres is necessary.

Other health care branches

All other health care branches in contact with addicts daily must respect the basic principle of addiction treatment – that it is a chronic recidivist disease. For the addicts following a maintenance treatment programme, continuation of treatment on admission to any hospital ward must be carried out in accordance with the instructions of a competent professional from the addiction prevention centre. Infectologists and hepathologists (internal medicine doctors) should promote treatment possibilities for addicts with chronic liver disease due to the high rate of hepatitis B and C infection in addicts.

4.3 Addiction reference centre

Due to the need for a single doctrine and methodology, as well as the improvement of monitoring, diagnostics, addiction treatment and addict rehabilitation, a reference centre under the Ministry of Health and Social Security in the field of addictions was established.

In accordance with the legal regulations, a basic task of the reference centre, apart from its main activity, is participation in undergraduate and graduate courses, and the continuing education of professionals dealing with addiction control. The reference centres also organise practical work, publish educational materials, and offer professional assistance and professional supervision in the field of prevention, diagnostics and addiction treatment and addict rehabilitation (including the Croatian Army, judicial system, etc.). The reference centre co-operates with domestic and international

institutions dealing with addiction prevention, diagnostics, treatment and rehabilitation of addicts, as well as addiction conditions and research.

4.4 Therapeutic communities and drug addiction rehabilitation centres

Therapeutic communities can be organised within the social security system and judicial system and they can operate as autonomous institutions for the withdrawal and rehabilitation of drug addicts within the system of religious and non-governmental organisations, in accordance with the relevant legal regulations. Within the social security system, therapeutic communities can be established with professional programme guidance for at least 100 users. The top priority is to organise two programmes that would enable training for working with minors and young addicts.

Religious and other non-governmental organisations and institutions can also organise therapeutic rehabilitation programmes, as well as programmes of psychosocial assistance, which will complement and further enrich drug addict care. Linking the therapeutic community and any other therapeutic or rehabilitation centre to the addiction care network must be previously verified and approved by the government body of the Republic of Croatia which is competent for drug abuse control. Professional supervision of the work in therapeutic communities and the implementation of the rehabilitation programme must be agreed by the ministry responsible for social security.

5 Services

The approach to treatment of drug addiction is based on the treatment guidelines identical to other chronic non-infectious diseases. Treatment needs to be planned and implemented in compliance with the needs of the individual and modified accordingly as the state of the disease alters over time. The treatment of drug addiction takes into account already proven measures that are supported by scientific evidence and positive outcomes. Acknowledging the chronic relapsing course of the disease, the organisational framework for the treatment of drug addiction is based on outpatient treatment in the network of county services for drug addiction prevention. This model considers essential the continuous co-operation and joint activity of specialised outpatient services for drug addiction prevention and general practitioners, that is teams of family medicine in the implementation of treatment programmes. This model allows broad accessibility to treatment through the primary health care system with the simultaneous assurance of specialised expertise, integrated care for drug addicts, destigmatisation and normalisation of treatment, decentralisation and inclusion rather than exclusion of addicts, as well as low costs of the treatment programme.

5.1 Treatment principles

5.1.1 The principle of approaching addiction as a chronic recidivist disease

Firstly, addiction treatment is conducted on an organised basis within the health care system of the country and particular measures of treatment and rehabilitation can be carried out outside the health care system. The approach to addiction treatment is based on an identical approach to the treatment of other chronic, non-infectious diseases. The treatment is planned and implemented according to the individual's needs and changed if needed, depending on the condition. During treatment only proven therapeutics and listed procedures are used.

5.1.2 The principle of organisation and course of treatment

Because of the chronic, recidivist course of the disease, drug addiction treatment in the Republic of Croatia is basically outpatient treatment. The Croatian model relies on the constant co-operation and joint activities of the outpatient centres for prevention and treatment of addicts and the primary health care physicians, in other words the family health care teams, in addiction treatment.

5.2 Treatment modalities

In the Republic of Croatia treatment of drug users is conducted through substitution pharmacotherapy and drug-free programmes, as well as through family and psychosocial treatment. This model enables wide availability of treatment through primary health care led by a specialist, wholesome care of addicts, treatment destigmatisation and normalisation, addiction decentralisation and inclusion within society, alongside low cost treatments. In the case of an addict's non-co-operation and aggressiveness, forced treatment may be considered in accordance with the adequate legal regulations. This would only arise if there was a likelihood that the addict's life was under severe risk or there was a danger of more severe health damage or harm to other people's safety and health.

The first contact for the drug addict with the treatment system would probably have occurred through the services for addiction and prevention.

5.2.1 Drug-free treatment

Within the health system in Croatia, drug-free treatment is available in inpatient health settings (the Vrapče psychiatric hospital in Zagreb and the Pula general hospital) as well as in outpatient settings in the framework of the national network of services for addiction and prevention. Although the aforementioned services play a significant role in substitution therapy, they also provide psychosocial treatment, usually in the form of counselling.

For those addicts motivated to follow a drug-free programme, one of the possibilities is a long-term stay (up to two years) in a therapeutic community. The rehabilitation programme in the therapeutic communities is based on well-controlled and structured programmes that will be able to attract particular clients in the open market with the aim of self-financing.

5.2.2 Substitution treatment

The National Drug Control Strategy in the Republic of Croatia, approved by the Croatian Parliament in 1996, defines the basic guidelines for methadone treatment. According to the national strategy, the process of methadone prescription is regulated in that a general practitioner receives an original letter from the authorised physician of the centre for the prevention and outpatient treatment of addiction, defining the quantity of a prescribed daily dosage of methadone. The general practitioner is required to store the letter in his/her documentation in order to be able to account for the prescribed quantity of methadone. The required dosage of methadone is given to a drug user dissolved in a vitamin drink or a fruit juice which the drug user is required to consume at the general practitioners in the presence of an authorised medical person. The dosage of methadone for weekends and holidays can be given by a general practitioner to a drug user dissolved in fruit juice or via a family member. Methadone is used in the following types of treatment:

– short-term outpatient detoxification: used as an optional method at an early stage of treatment (overcoming physical addiction) and usually lasting for less than a month in cases of narcotic drug users who have not succeeded in maintaining abstinence, regardless of any methods tried to date;
– slow outpatient detoxification (up to six months): used in cases of drug users whose heroin addiction prevents them from maintaining abstinence and where no other drug-free treatment method has been successful; these are usually drug users who have been consuming drugs for at least five years;
– long-term methadone maintenance therapy by continually taking the same or approximately the same dosage: applied to drug users where no other form of drug-free treatment and/or detoxification has been successful and in order to enable them to maintain heroin abstinence; these are usually drug users older than 25 whose consumption of drugs has, on average, been for 10 years.

According to the aforementioned facts, it is obvious that in the Republic of Croatia general practitioners play an important role in implementing methadone treatment since they are most often in direct contact with drug users and can, therefore, notice any changes and refer them to experts or provide them with help themselves. In the Republic of Croatia methadone has been

used in practice in an insufficiently controlled manner due to the fact that the indications for methadone treatment were very broad and the method of prescribing methadone lacked the necessary control. Furthermore, prescriptions for methadone and methadone itself were often given directly to drug users and it was then used in unjustifiably high dosages. There was, therefore, a need to bring methadone treatment for narcotic drug users under control and to standardise the criteria for its use, as well as to reduce its misuse and the negative consequences of uncontrolled use, including the possibility of a fatal outcome due to methadone overdose. The guidelines for the use of methadone in substitution therapy for narcotic drug users have been drawn up, following a proposal from the Ministry of Health and Social Welfare and these were adopted by the Croatian Government on 3 January 2006. In December 2006, guidelines for the use of buprenorphine in substitution therapy for narcotic drug users were also created by the Minister for Health and Social Welfare on the basis of the conclusions of the Commission for Combating Narcotic Drug Misuse, leading to the inclusion of buprenorphine (Subutex) in the list of drugs approved by the Croatian Institute for Health Insurance.

5.2.3 Treatment in prison settings

Treatment of prisoners who are drug users is part of the National Strategy on Combating Narcotic Drugs Abuse, according to which the prison administration must ensure conditions suitable for the quality organisation of work with prisoners, that is, they should create appropriate programmes and provide a suitable area and teams of experts. The following must also be followed through: continuous education and training of the judiciary police, health workers and professional staff (social workers, teachers and psychologists), as well as sensitisation of administrative staff to the problems drug users experience and to drug dependence. In connection with the treatment of prisoners within the prison system, at Lepoglava penitentiary a special ward was established for prisoners who were diagnosed with narcotic drug dependence. The ward is organised according to the principles of a modern therapeutic community, while the prisoners who begin treatment sign a suitable therapeutic contract. Treatment programmes for drug users are conducted at other prisons/penitentiaries. Exceptional co-operation was achieved with the centres for the prevention of drug dependence and treatment outside the hospital as well as with the non-governmental and other organisations which carry out programmes for post-release reintegration of prisoners. Furthermore, at Turopolje, a correctional home for juveniles, a treatment programme for adolescents who have abused narcotic drugs is in place.

For the purpose of establishing more efficient mechanisms for preventing narcotic drugs from entering the prison facilities as well as narcotic drug

abuse on the part of the prisoners, nine machines for urine testing were acquired and urine tests were carried out in order to enable the detection of narcotic drugs. For the prisoners who are drug users, have undergone suitable treatment within the prison system and achieved satisfying results, and who also need to participate in a special programme, in part at the penitentiary and in part within the social community outside the prison facility, preparations for forming a special socio-therapeutic penitentiary have begun within the Valtura Penitentiary. The Act on the Execution of a Prison Sentence, Articles 20 and 69, prescribes requirements for the penitentiaries regarding prisoners who are drug users, as well as regarding individual programmes for those serving a prison sentence.

6 References

www.uredzadroge.hr – the Office for Combating Narcotic Drug Abuse
www.hzjz.hr – Croatian National Institute of Public Health
www.dzs.hr – Central Bureau of Statistics

Hungary

1 Demography

Hungary has a total area of 93 030 square kilometres and a population of above 10 million people. As a result of the Treaty of Trianon in 1920 and population transfers after the Second World War, Hungary became one of the most ethnically homogeneous countries in eastern Europe. The largest ethnic minority is the Roma (2.1%).

Administratively, Hungary is divided into 19 counties and the capital, Budapest, which is independent of any of the counties. Since 1996 the counties have been grouped into seven regions. Budapest has a population of almost 2 million people, while the second largest city's population is only 200 000. Besides Budapest there are eight other cities which have a population of above 100 000 inhabitants.

Since 1989, Hungary has undergone rapid and fundamental economic and social changes, in connection with the transition from a largely state-owned command economy to an almost fully privately owned market economy. During the early years of transition, overall production dropped significantly, with unemployment soaring and inequalities rapidly increasing. From the mid-1990s the process has somewhat stabilised and production has been steadily growing, together with the average standard of living. However, in the past year, as a result of reform arrangements, the standard of living has dropped. Inequalities seem very well entrenched, with about one quarter to one third of society trapped in long-term poverty. Unemployment, which dropped below 6% in 2001, has slightly increased in recent years (7.2% in 2005 and 7.5% in 2006).

2 Epidemiology of drug use

Before the political changes in 1989 the prevalence of illegal drug use was low in Hungary. Though drug use was apparent at the end of the 1960s, up till the start of the 1990s it was mainly restricted to the use of medicines. Beside benzodiazepines, the anti-Parkinson medication, Parkan, was abused as a hallucinogenic drug, and since the 1980s codeine derivatives have been popular. Poppy was used in the form of poppy tea year round, while in the summertime injecting of harsh opium (gained by poppy cutting) was also common among opiate users. Inhalant use was also observed, mainly in the poorer, urban areas (Paksi and Demetrovics, 1999; Racz, 1992).

From the early 1990s, with the opening of the borders, access to illegal drugs became much easier. The earlier use of poppy tea, harsh opium and codeine derivatives was now replaced by heroin, mainly administered intravenously. The use of cannabis, which was earlier restricted to intellectual circles, started spreading and became widely available in a short period of time. Cocaine also appeared on the market, albeit in smaller quantities. LSD, amphetamine and ecstasy also became popular by the end of the 1990s, especially in the party culture (Demetrovics, 2001, 2006).

According to the results of the 1995 ESPAD survey, lifetime prevalence of illegal substance use among 16-year-old high school students was 4.8% (5.4% for boys and 4.2% for girls). However, this rate increased sharply over the next decade, with a lifetime prevalence of 12.5% (16.7% for boys and 8.3% for girls) in 1999 and 16.2% (18.4% for boys and 13.8% for girls) measured in 2003. Smaller scale surveys indicate that this increase is now on the decline (Elekes and Paksi, 1996, 2000; Paksi, 2007).

A national representative survey of the adult population (18-53 years) revealed a 7.5% lifetime prevalence of illegal drug use in 2001 and 11.1% in 2003. Past year prevalence was 2.8% and 3.9% respectively, while past month prevalence was 1.3% and 1.4% (Paksi, 2007).

The number of drug users in treatment has increased steadily during the past 10 to 15 years with a small drop between 2000 and 2003. In 1995 1 189 patients had registered for treatment in the health care system because of their use of illicit substances, while this number had grown to 8 170 by 2000. This number dropped to 5 638 in 2002 and then started to increase again, up to 9 777 in 2006 (National Focal Point, 2007; see Figures 1 and 2). The number of those treated with cannabis-related problems increased from 1 806 in 2002 to 5 842 in 2006, but it has to be noted that this increase is largely attributable to the system of "diversion" (the possibility of entering treatment as an alternative to the legal process or imprisonment). Apart from this, no relevant increase can be observed in the number of drug patients. The mortality of drug users ranged between 20 and 50 in the period 2000-2004, and the cases were mostly heroin overdoses.

HIV infection among intravenous drug users does not constitute a huge problem at the present moment in time in Hungary (see Figure 3). Over the past two decades only a few individuals infected with HIV have been identified. However, hepatitis C infection prevalence among patients of the drug outpatient centres and harm-reduction services was 28.9% in 2006 (National Focal Point, 2007).

Figure 1: The number of drug users according to the substance used (2002-2006)

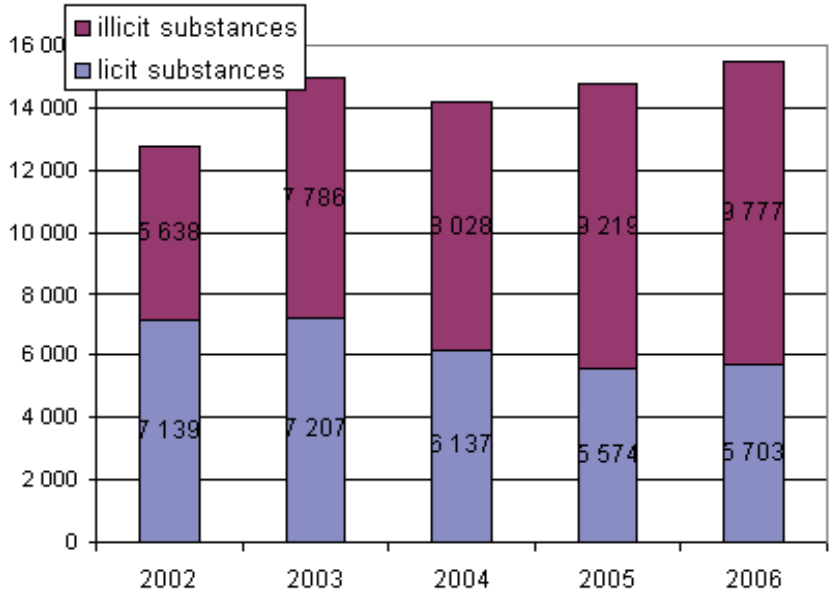


Figure 2: Number of patients treated according to the primary drug used (2002-2006)

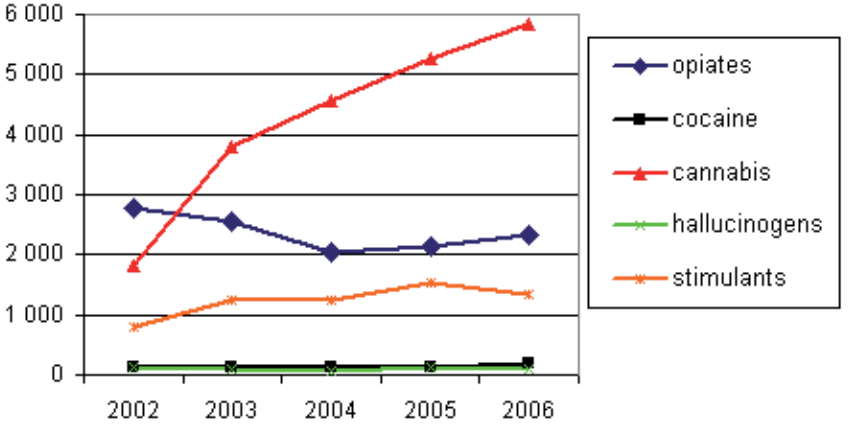
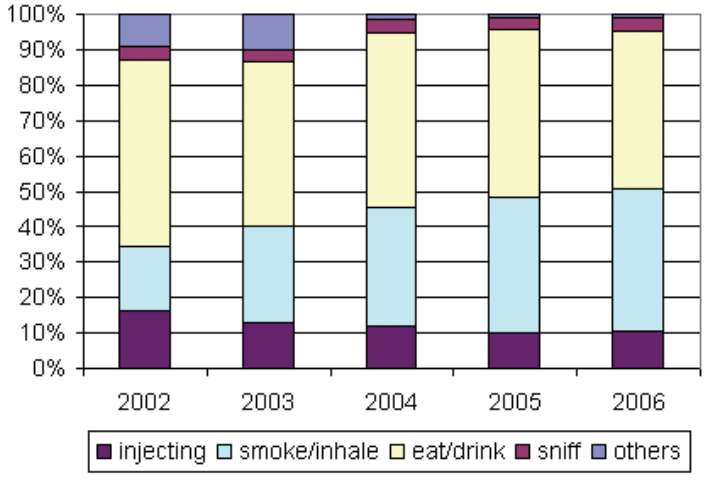


Figure 3: The proportion of drug users according to the usual route of administration (2002-2006)



3 Short history of drug treatment

Treatment for drug users is on offer at various outpatient and inpatient facilities throughout Hungary. Facilities include specialised drug clinics and therapy-providing institutions, as well as psychiatric departments, therapeutic communities and crisis intervention departments. The need for developing outpatient institutions specialised in the treatment of drug dependent patients was identified in the 1980s, and the first services were established between 1987 and 1989. In 1999, drug outpatient centres set up an association to represent their interests and the members of this association cater for the majority of dependent drug users in the outpatient system. Overall there are 21 specialised outpatient centres operating in 13 counties and in Budapest. Inpatient care is offered by psychiatric departments, specialised addiction departments, crisis intervention departments and therapeutic communities run by NGOs and the churches. Besides the nine existing therapeutic communities, two new facilities were opened in 2003. Together, the 13 therapeutic communities (which are not only dedicated to treating illicit drug problems) offer a total of 400 treatment slots to patients.

Long-term rehabilitation is mainly provided by NGOs. The services they deliver are only partially medical/health care-orientated and are dominated by social and welfare programmes (e.g. work therapy, social reintegration).

As far as the prescription of substitution drugs is concerned, the "sporadic" use of methadone started in 1994. In 2004, two new treatment centres launched the Methadone Maintenance Treatment Programme. In 2007

the programme was available in eight institutions in six towns nationwide, but by the end of the year one of the centres was closed as a result of the restructuring of the health care system.

Treatment in out- or inpatient departments implies that it is mainly medical treatment, but it is sometimes complemented by social reintegration programmes. The treatment personnel mainly have medical backgrounds (psychiatrists, psychologists, nurses, sometimes social workers). Medical doctors and psychologists very often have a specialised degree and are "addiction medicine specialists". The number of doctors and psychologists working in the addiction field, as well as the number of addiction specialists, is low according to a survey conducted by the Ministry of Health in 2004. The treatment system also has difficulties in organising supervision and case conferences. This contributes to the frequent "burn out" of treatment personnel.

Treatment in Hungary mainly includes medical, psychological or social intervention for the drug user but it is not restricted to only working with drug dependent patients. However, the inpatient departments and therapeutic communities treat dependencies while outpatient centres are rather more open to treating abusers or problem users.

3.1 Treatment registries and monitoring systems

On 9 May 2006, the data collection system based on treatment demand indicators (TDIs) at treatment centres was officially introduced through Regulation 20/2006 (V.9) of the Ministry of Health. Since then, treatment centres with a high client turnover can make use of specific offline software to record clients' data (and later transmit them electronically via the Internet to the National Institute for Addiction), while centres with a lower number of client visits can do so directly online. This data collection system is applied not only in treatment centres in the field of health care, but also in low-threshold agencies and treatment units in prisons. However, data on addiction treatment provided by general practitioners are currently not collected. As from January 2007 onwards, the Hungarian TDI system has been made fully compatible with European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reporting standards.

4 Organisation of treatment services

Based on 2004 survey data (Ministry of Health) there are approximately 400 health facilities in Hungary where drug users are treated. Besides the traditional role of addiction care providers the role of the outpatient centres is also increasing. While varied outpatient care is available dependent on the type of care providers and specialised outpatient centres, inpatient care is not in that it is based on the medical model and treatment occurs within

psychiatric and addiction treatment departments. As mentioned above, there are specialised outpatient centres for illicit drug users and other "addiction-type" centres for illicit and licit drug users, as well as for alcohol dependent patients. At inpatient psychiatric departments illicit drug users, licit drug users and alcohol patients are treated together, alongside other psychiatric patients. The specialised outpatient centres are mostly run by NGOs, while the other treatment facilities are public ones. The long-term residential departments (mainly therapeutic communities) are run by NGOs or the churches. The ministry in charge of treatment issues is the Ministry of Health, while national co-ordination of drug affairs is the remit of the Ministry of Social Affairs.

Based on the 2004 survey related to personnel capacity, only one full-time doctor – not necessarily a psychiatrist or addiction expert – is based at each treatment centre on average. The number of social workers is also very low albeit a significant number of addiction clients face serious social problems. Special workers and assistants are also few in number; on average 3.8 persons work in one treatment centre and a mere 2.2 are in place to support one doctor. At the same time the number of unfilled positions would appear to be a perennial problem as well as the provision for the correct complement of staff. Professional qualifications of doctors and psychologists are also rather incomplete: 20.8% of doctors and only 3.1% of psychologists have graduated as addiction experts. According to data available professional minimum standards are only partially fulfilled in the majority of treatment centres.

Treatment centres apply different therapeutic methods depending on the treatment on offer. Consultative-psychotherapeutic interventions are the most frequently applied.

According to the survey mentioned above, the following drug-free therapeutic methods are applied by the treatment centres.

- supportive therapy (basic psychotherapy) (45.3%)
- mental health consultation (41.5%)
- crisis intervention, crisis therapy (37.3%)
- consultation/counselling (31.6%)
- social case management (27.4%)
- group methods (25.0%)
- family therapy (22.6%)
- socio-therapy (22.2%)
- special psychotherapeutic methods (19.8%)
- relaxation (19.8%)
- art therapy (15.6%)
- healing treatment, ergotherapy (11.3%)

– movement therapy (9.4%)
– acupuncture detoxification (7.1%)
– other (2.8%).

Since 2003, two forms of treatment alternatives to punishment have existed. In the case of dependence or severe drug use treatment is available in health care facilities (mostly in specialised outpatient centres). In the case of occasional drug use, prevention centres are also eligible to provide their services for these drug users in the form of prevention-educational programmes (see details below).

5 Services

5.1 Detoxification

Drug users receive detoxification treatment in general psychiatric departments or at one of the few specialised addiction treatment departments. In many cases detoxification is not followed by aftercare or any treatment aimed at rehabilitation and the maintenance of abstinence. In these cases relapse is extremely frequent. However, in comparison to the situation of some years ago, planned detoxification (for instance as preparation for long-term treatment in a therapeutic community) occurs more and more frequently. In contrast to the former practice, opiate agonists (methadone) are less frequently used during detoxification.

5.2 Evaluation/planning of treatment

In Hungary there is no systematic evaluation of addiction treatment. However, a few small-scale studies have examined some forms of addiction treatment (Demetrovics & Kardos, 2001; Csorba et al., 2007). Gerevich, Bacskai and Rozsa (2003) reviewed the situation within the drug outpatient centres. Marian et al. (2004) conducted a qualitative evaluation of an outpatient and a low threshold service. Marvanykovi and Racz (2005) and Melles, Marvanykovi and Racz (2007) evaluated low threshold services for problem drug users.

5.3 Treatment

5.3.1 Substitution treatment

The first experiments with substitution treatment were registered in 1989 at one of the outpatient centres in Budapest. This time codeine and dihydrocodeine were used as substitution medicine and the number of patients receiving substitution treatment was low. As a result of the increase in the number of opiate addicts the need for substitution treatment has also grown. Though methadone has been in use in Budapest since 1994 and in Pecs since 1995 the number of patients has remained very low. In 1999 a total of 88 patients received methadone as a substitute for heroin (Demetrovics et al.,

2001). However, with the approval of the Methadone Treatment Protocol by the College of Psychiatrists in 2001 the broadening of this kind of treatment has now become possible. In 2006, the total number of clients in methadone maintenance treatment was 853, treated in eight centres (six cities). The majority (78%) of clients were treated in Budapest.

Suboxone (buprenorphine and naloxone combination) has been available in Hungary since November 2007 at five drug outpatient centres. A total of 34 patients received Suboxone in 2007 in Hungary.

5.3.2 Drug-free treatment services

In Hungary 13 long-term residential treatment centres offer drug-free treatment for addicts. They are run by NGOs and the churches, but are partly financed by the national insurance fund and/or the Ministry of Social Affairs.

Drug-free treatment services vary in their philosophy, for example in their treatment methodology or length of treatment (in most cases six to 18 months). At some institutions only males are accepted for treatment, while other centres accept both male and female patients. One centre only accepts female patients.

5.3.3 Dual diagnosis treatment

In Hungary there are no specialised treatment centres for drug patients with other psychiatric diagnosis. Patients with dual diagnosis are treated at drug centres or at psychiatric departments.

5.3.4 In/outpatient

According to the National Statistical Data Collection Programme statistics on 1 December 2004, the total number of beds in psychiatry (addiction treatment included) was 9 500 and responding treatment centres cover 50% of the inpatient care capacity. This rate does not reach 40% in the case of day-care centres.

The same statistics indicate that the number of beds in addiction treatment (within the number of beds in psychiatry) is around 1 200.

Outpatient special care is divided into outpatient centres belonging to inpatient departments and special centres not belonging to departments and care centres. Outpatient centres vary considerably, for example in infrastructure, professional activities, financial background, ownership, availability of specialised personnel and client turnover. Currently there is no outpatient centre in two counties.

Larger care centres are able to provide outpatient treatment for both alcohol and drug addicts, but the majority of care centres are small centres where the lack of professionals and infrastructure do not allow the efficient and mass treatment of drug users. Due to the facts described above in some regions drug users have to cover a significant distance in order to get special care.

The new legislation since 2003 has widened the possibility of choosing treatment as an alternative to the legal process. As a result, the number of those in treatment to avoid criminal proceedings has increased, mainly due to the marijuana users against whom criminal proceedings were begun (see Figures 4 and 5).

Figure 4: Number of those in treatment as an alternative to criminal proceedings (2002-2006)

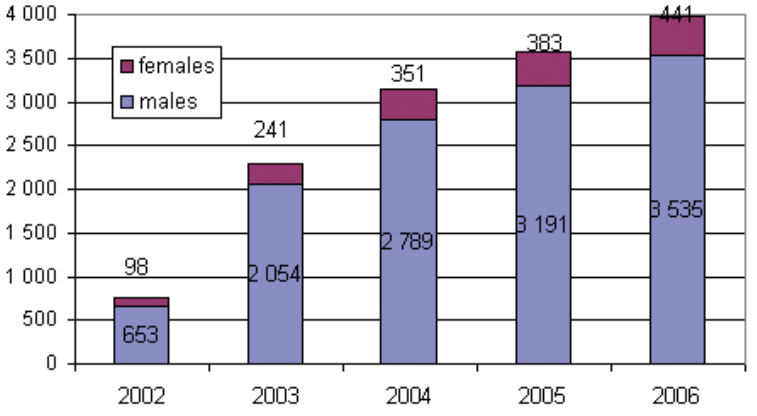
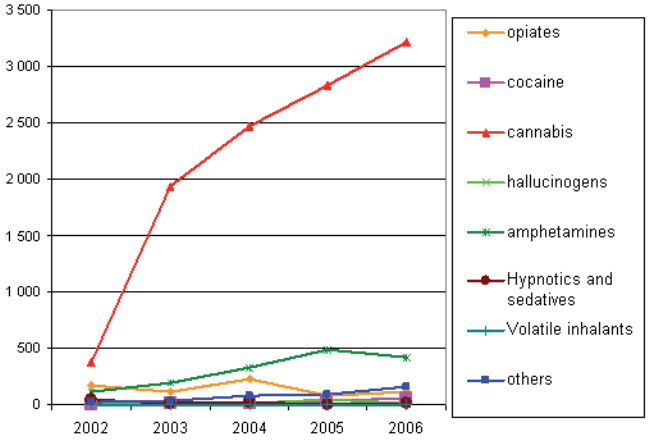


Figure 5: Number of those in treatment as an alternative to criminal proceedings according to the primary drug used (2002-2006)



5.3.5 Drug and/or alcohol and prescribed drugs

Inpatient departments (mostly psychiatric departments not specialised in addiction) treat drug and alcohol dependent patients. "Addictological" outpatient centres treat illicit and licit drug users as well as alcohol dependent

patients. Specialised outpatient centres treat only illicit drug users (drug users with different severity of drug use).

5.3.6 Availability/link to somatic and psychiatric treatment

The systematic treatment of co-occurring psychiatric diseases (drug problems/abuse/dependence and other psychiatric problems) is absent as well as the systematic referral of patients with drug and psychiatric problems for psychiatric treatment. In most of the cases co-morbidity is under diagnosed.

5.3.7 Rehabilitation services linked to treatment

There are long-term residential services linked to rehabilitation programmes (vocational services, housing, etc.).

5.3.8 Treatment of young people

The majority of the treatment centres take care of adults, but quite a few places undertake the treatment of the 16-18 age-group too. However, treatment of adolescents and children (under 16-17 years) is difficult: there is no specialised health care department for these drug using patients.

5.4 Gender issues

Gender issues are not handled specially in the treatment of drug users and addicts. There are no special treatment services available for female addicts, with the only exception of one residential treatment centre.

5.4.1 Pregnant women/families with small children

No specialised treatment services are available for pregnant addicts. However, obstetricians do consult with addiction experts on the special needs of addicted pregnant women, and issues concerning the delivery and the treatment of the newborn.

5.5 Treatment within the criminal system

From 2002 onwards there were about 200-400 drug users in the criminal system who participated in treatment programmes. There is also the facility to place drug users in the so-called “drug prevention units” inside the prison. Methadone maintenance or other substitution treatments are not available inside the criminal system.

6 Strengths and weaknesses

Strengths:

– low level of drug mortality;

– low level of HIV infection and relatively low level of hepatitis C infection among injecting drug users;
– the possibility and the presence of community addiction care approach.

Weaknesses:

– interruption of the treatment continuum (spectrum);
– low capacity of addiction treatment (especially inpatient treatment, aftercare and follow-up), relative lack of rehabilitation and reintegration services;
– lack of children and adolescent treatment places;
– low territorial coverage of the country by treatment services;
– lack of evaluation, low level of quality management;
– poor community addiction treatment through the integration of health care and social services;
– lack of finance through the National Insurance Fund;
– no methadone maintenance in the criminal system;
– no specific addiction training/specialisation of professionals;
– the unclear role of the local drug co-ordination forums in the organising and planning of treatment services;
– low coverage of low-threshold (harm-reduction) services.

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Lithuania

1 Demography

The Republic of Lithuania is a country in northern Europe. Situated along the south-eastern shore of the Baltic Sea, it shares borders with Latvia to the north, Belarus to the south-east, and Poland and the Russian enclave of the Kaliningrad Oblast to the south-west. Lithuania has been a member state of the European Union since 1 May 2004. Its area is 65 200 and it has an estimated population of 3 384 879 (2007), of which 1 586 650 are men and 1 807 916 are women (see Table 2). Vilnius is the largest city and the capital of Lithuania, with a population of about half a million inhabitants.

Table 2: Population of Lithuania by sex and age

Age-group	Total		Males		Females	
	2006	2007	2006	2007	2006	2007
Total	**3 403 284**	**3 384 879**	**1 586 650**	**1 576 963**	**1 816 634**	**1 807 916**
0	30 347	31 081	15 507	15 780	14 840	15 301
1-4	121 157	120 234	62 135	61 690	59 022	58 544
5-9	178 684	171 422	91 969	88 268	86 715	83 154
10-14	230 205	215 386	117 779	110 049	112 426	105 337
15-19	271 074	265 721	138 456	135 540	132 618	130 181
20-24	259 143	267 385	131 841	136 105	127 302	131 280
25-29	225 350	226 912	114 124	115 719	111 226	111 193
30-34	235 563	228 712	116 951	113 760	118 612	114 952
35-39	249 039	248 303	122 108	121 875	126 931	126 428
40-44	265 783	257 819	129 576	125 838	136 207	131 981
45-49	254 253	262 434	120 106	124 110	134 147	138 324
50-54	207 628	210 103	95 901	96 914	111 727	113 189
55-59	181 105	187 456	79 666	82 555	101 439	104 901
60-64	172 141	164 640	72 090	68 618	100 051	96 022
65-69	164 802	163 563	64 495	63 978	100 307	99 585
70-74	143 074	143 891	51 746	51 952	91 328	91 939
75-79	113 606	115 005	36 639	37 732	76 967	77 273
80+	100 330	104 812	25 561	26 480	74 769	78 332

2 Epidemiology of drugs use

Prior to 2004, Lithuania, together with a limited number of countries, did not have prevalence estimates of drug use for the general population as no surveys had been conducted. The general population survey on the

prevalence of drug use in the country was carried out in 2004, according to the methodology of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The target group of the study was permanent residents of Lithuania aged 15-64. The survey results show that 8.2% of the Lithuanian population aged 15-64 used drugs at least once in their lifetime (13.1% of men and 3.8% of women). The younger Lithuanian population (aged 15-34), more frequently than the older population (35-64 years), indicated that they had tried drugs at least once in their lifetime (14.1% and 3.8%, respectively) (2004 National Survey data). Cannabis is the most commonly used drug, and 7.6% of the Lithuanian population reported that they had used it at least once in their lifetime. The rate of cannabis use at least once in their lifetime among men is three times higher than among women (12.1% and 3.4%, respectively). In Lithuania, besides cannabis the most common drugs are amphetamine and ecstasy, with very similar use rates. The prevalence of drug use at least once in their lifetime among the Lithuanian population is as follows: amphetamine – 1.1%, ecstasy – 1.0%, hallucinogenic mushrooms – 0.5%, cocaine – 0.4%, heroin and LSD – 0.3%.

Similar to many countries in central and eastern Europe, lifetime experience with illegal drugs increased significantly during the 1990s, as shown by the ESPAD surveys conducted in 1995 and 1999. Except for lifetime prevalence rates of inhalant use and use of tranquillisers/sedatives without medical prescription, the experimentation with illegal drugs increased among students in Lithuania between 1995 and 1999. However, the data from the ESPAD survey conducted in 2003 show that this trend is slowing down. Lifetime experience of any illegal drug other than marijuana/hashish among students aged 15-16 years old increased from 2% in 1995 to 9% in 1999, but decreased to 7% in 2003. Cannabis is the most frequent illicit drug experimented with among this age-group, with 13% having used cannabis at least once during their lifetime in 2003 (12% in 1999 and 1% in 1995). With regard to amphetamine and ecstasy the trend was reversed for ecstasy use. While lifetime prevalence rates for amphetamine increased to 5% in 2003 (2% in 1999, 0% in 1995), lifetime experience with ecstasy decreased to 2% in 2003 (4% in 1999, 0% in 1995).

In 2006, the prevalence of psychoactive substance use among inmates in foster homes of local governments and counties was as follows: 19% of the subgroup aged 15-17 reported using at least one drug in their lifetime, 12% at least once in the last 12 months and 8% in the last 30 days.

As of 31 December 2006, the health care institutions registered 68 951 individuals with mental or behavioural disorders caused by psychoactive substances, including 5 573 individuals with dependence disorders caused by drugs and psychotropic substances. In 2006, of the total number of registered individuals with mental or behavioural disorders caused by psychoactive substances, men accounted for 81.3% (4 529) and women 18.7%

(1 044). In 2006, there were 287.2 cases per 100 000 population of male drug dependence morbidity, and for female drug dependence morbidity there were 57.7 cases per 100 000 population. In 2006, as in previous years, the biggest share of all registered individuals with mental or behavioural disorders caused by drugs and psychotropic substances were opioid users. In 2006, the number of registered individuals with mental or behavioural disorders caused by using opioids amounted to 4 481 individuals (80.4%); cannabioids – 30 individuals (0.5%); tranquillisers and sedatives – 80 individuals (1.4%); cocaine – 8 individuals (0.1%); stimulants including caffeine – 139 individuals (2.5%); hallucinogens – 8 individuals (0.1%); volatile substances – 158 (2.8%); multiple drugs and other psychoactive substances – 668 individuals (12%).

In 2006, the health care institutions registered 323 new cases due to mental or behavioural disorders caused by drugs and psychotropic substances, that is, 26 individuals (7.5%) fewer than in 2005.

In 2006 in Lithuania, 100 new HIV cases were diagnosed, that is, in 20 individuals fewer than the previous year (2005 – 120, 2004 – 135, 2003 – 110). Among the new HIV cases men prevailed – 88 individuals. Within the period from 1988 when the first HIV case was diagnosed in Lithuania to 1 January 2007, 1 200 HIV-infected individuals were diagnosed. The number of HIV-infected men exceeds that of women by seven times, but the comparative rate of infected women is increasing. The ratio of newly infected men and women in 2002 was 12:1, falling in 2003 to 7:1 and in 2004 to 5:1. In 2005 it was reduced to 3:1, and in 2006 it was 3.5:1. In 2006, among new HIV cases 62 individuals (62%) were infected with HIV through injecting drugs. Within the last three years the trend has been that more people have been infected with HIV through sexual intercourse. The total HIV infection prevalence indicator in Lithuania was 29.41 cases per 100 000 population in 2006 (26.3 cases in 2005, 22.78 cases in 2004).

In 2006, the Lithuanian health care institutions registered 107 cases of acute viral hepatitis B. The morbidity rates of acute viral hepatitis B have tended to consistently decline over the last decade. The morbidity rate of acute viral hepatitis B declined from 5.42 cases per 100 000 population in 2004 to 3.14 cases per 100 000 population in 2006. Of the 107 individuals with hepatitis B, 16 were injecting drug users (14 men and 2 women). In 2001-2006, among all registered new hepatitis B cases, the share of injecting drug users continues to decline from 42.4% (2001) to 14.9% (2006). However, the number of cases with an unknown transmission factor causing this infection increased each year: in 2004, such cases accounted for 38% of all new hepatitis B cases whereas in 2006 this rose to nearly 50%. Taking into consideration the above, the reduced rate of injecting drug users among all registered hepatitis B cases should be assessed cautiously.

Again, in 2006, the Lithuanian health care institutions registered 62 cases of acute viral hepatitis C. The morbidity rates of acute viral hepatitis C have tended to consistently decline over the last five years. The morbidity rate of acute viral hepatitis C declined from 2.41 cases per 100 000 population in 2004 to 1.82 cases per 100 000 population in 2006. A large number of cases (51.6%) provided an unidentified contraction factor causing hepatitis C. Of the 62 registered acute cases, 13 individuals were injecting drug users. In 2001-2006, the share of injecting drug users among all registered hepatitis C cases declined from 59% (2001) to 21% (2006).

The mortality rate, according to data from the Department of Statistics of the Government of the Republic of Lithuania, with drug and psychotropic substance use as the main cause of death, was at its highest peak in 2006 in relation to the last five years. In 2006, 62 deaths due to drugs and psychotropic substance use were registered (in 2005 there were 31 cases), and this level accounts for 0.14% of all deaths registered in Lithuania (44 813 deaths). The increase of drug-related deaths in 2006 could be both due to subjective causes (total increase of mortality in Lithuania) and objective ones. In recent years the acquisition of new and more accurate laboratory equipment, improved methodologies and staff training, the requirement of higher qualifications, better IT implementation in the Institute of Forensic Medicine, increased inter-institutional co-operation and exchange of information, as well as other factors, have led to improved quality and comprehensiveness of collected data.

According to age distribution in 2006, the largest number of deaths was in the young subgroup aged 20-34 (45 individuals), with the average age of 29.7 years (men – 29.78, women – 29.5). In Lithuania in 2006, the estimated life expectancy for men was 65.3 years, and for women it was 77.1 years.

3 Short history of drug treatment

In Lithuania the main juridical acts which regulate treatment of addictive drug disorders, psychotropic and other substances that influence behaviour are the Republic of Lithuania Law on Narcology Care (1997), the Law on Mental Health Care (1995), and the Law on Patients' Rights and Compensation for Damage to Patients' Health (2004).

On 3 April 2007 the Seimas of the Republic of Lithuania approved the Strategy on Mental Health through Decision No. X-1070 "For mental health strategy confirmation" (Žin., 2007, No. 42-1572). One of the main tasks of this strategy is to ensure both that due attention is given and financial resources allocated to tackle all the main public mental health care problems – alcohol and drug addiction, suicide, violence and mental illness.

Health care for addiction disorders is complex and treatment services, including medical treatment, are available together with social help and

psychosocial rehabilitation. These are organised under the requirements of the addiction disorders treatment and rehabilitation standards which were confirmed on 3 May 2002 by the Minister of Health of the Republic of Lithuania under Order No. 204 (Žin., 2002, No. 47-1824).

Treatment is applied on an individual basis and the treatment and rehabilitation plan is prepared for each patient with psychiatrists, psychologists, nursing specialists, social workers and family doctors participating in the implementation of this plan. Legislation requires that addict patients' health care is supported by state (in other words, it is free).

In Lithuania, 73 mental health centres offer an outpatient first level addictive disorders treatment and rehabilitation service.

Special second level outpatient and inpatient addictive disorders treatment and rehabilitation services are available at five addictive disorders centres, which are located in the largest cities, namely: Vilnius, Kaunas, Klaipėda, Šiauliai and Panevėžys.

According to government mental health centre data (2006) on people in health care institutions, a total of 68 951 people were registered, 5 573 persons for mental and behavioural disorders due to use of drugs and psychotropic substances. In 2005, 68 701 persons were registered, 5 371 of them due to use of drugs and psychotropic substances.

In 1995, Lithuania began to apply the methadone programme. The main problem is accessibility of substitution treatment in recent years. In 2007, in an attempt to improve substitution treatment accessibility and quality, the Minister of Health of the Republic of Lithuania approved the application of substitution treatment against opioid dependence and the prescription, delivery, keeping and accounting of substitution opioid pharmaceuticals in health care institutions through Decree No. V-653 on 6 August 2007. In Lithuania one is allowed to use not only methadone hydrochloride but also buprenorphine hydrochloride. Health care institutions are required to provide information on the effectiveness of surrogate substitution treatment for each patient to the State Mental Health Centre.

In 2008 in Lithuania, the EMCDDA reacted to a demand for a drug treatment epidemiological index. On 1 August 2007, the Minister of Health of the Republic of Lithuania approved a new monitoring system for people who apply to health care institutions as a result of their use of drugs and/or psychotropic substances through Order No. V-636 "Monitoring order inventory for people who apply to the health care institutions due to mental and behavioural disorders, using drugs and psychotropic substances conformation" (Žin., 2007, No. 88-3496).

Lithuania participates in the United Nations project "HIV/Aids prevention and care among injecting drug addicts and in prison settings in Estonia,

Latvia and Lithuania". The main aim of the project is to create a favourable environment in all countries participating in this project that would enable them to improve the implementation of HIV/Aids prevention and safe practice among injecting drug addicts, including those in prison.

4 Organisation of treatment services

According to the data of the Lithuanian Health Information Centre, medical assistance is provided by 1 066 outpatient institutions providing various services and 196 institutions providing inpatient medical assistance services. General practitioners, therapists and paediatricians working in primary health care institutions, when they suspect a patient to be dependent on psychoactive substances and have identified any symptoms of the disorders, send the patient to a psychiatrist for counselling. In Lithuania, primary mental health care is practised by 85 mental health care institutions. The staff at the beginning of 2008 at all 85 institutions included 156 psychiatrists for adults, 39 juvenile psychiatrists, 223 medical nurses, 167 social workers, 110 psychologists and 36 narcologists.

According to data from the State Service for Accreditation of Health Care Activities under the Ministry of Health of the Republic of Lithuania, at the beginning of 2007, 256 institutions possessed the right to engage in individual health care activities including psychiatric services, dependence disorders psychiatry, psychotherapy and juvenile psychiatry. According to information from the State Mental Health Centre, statistical data was only provided by 74 individual health care institutions out of all the accredited institutions.

Outpatient treatment is provided in primary health care institutions, mental health centres or psychiatric clinics and private institutions. In addition, outpatient treatment is provided in outpatient units in the centres for addictive disorders.

Inpatient treatment is provided by five specialised centres for addictive disorders in Vilnius, Klaipėda, Šiauliai, Panevėžys and Kaunas.

First aid treatment for intoxication or coma is provided in toxicology or intensive treatment units. Instant detoxification for psychoactive substance users is applied in toxicology units and private toxicology clinics.

In recent years detoxification and short-term rehabilitation divisions and units for children using psychoactive substances were established in the existing health care institutions. The treatment period may last up to one month and include detoxification, treatment with pharmaceuticals and development of motivation. Currently, the centres for addictive disorders have 18 beds for treatment and short-term rehabilitation of children dependent on psychoactive substances (9 in the Vilnius Centre for Addictive

Disorders, four in the Klaipeda Centre for Addictive Disorders, five in the Kaunas Centre for Addictive Disorders). The rehabilitation service can be last from one to three months. In 2006, the centres for addictive disorders treated 17 children in Vilnius, 11 in Kaunas and four in Klaipėda.

5 Services

5.1 Detoxification

Detoxification can be carried out in all health care institutions, as required, taking into account the patient's condition. Detoxification should be carried out by licensed medical doctors (Law on Narcological Care of the Republic of Lithuania, 1997).

In October 2008, the monitoring began of individuals using drugs and psychotropic substances who contacted health care institutions regarding mental and behavioural disorders, following approval of the monitoring procedure under Order No. V-636 of 1 August 2007 (Žin., 2007, No. 88-3496). The health care services provided will be analysed, including abstinence treatment (detoxification) services.

5.2 Evaluation/planning of treatment

Currently, the legal acts in effect do not establish the frequency of tests for participants in the maintenance treatment programme regarding potential use of other psychoactive substances. So far participants in the maintenance treatment programme are tested only if a treating doctor suspects his/her patient is using other psychoactive substances. Thus, in 2006 only 790 participants in the maintenance treatment programme were tested. Due to targeted selection, that is, only patients in treatment suspected of using drugs were tested, instead of all or randomly selected ones, positive tests of use of drugs and psychotropic substances among randomly selected participants were identified in 312 cases, or 44.5% of all tests, including: 100 cases (32.1%) using opioids, 35 cases (11.2%) using stimulants, 199 (63.8%) using tranquillisers and sedatives, nine cases (2.9%) using hallucinogens and 28 cases (8.9%) using other psychoactive substances. Among participants in the maintenance treatment programme no positive tests for cocaine were identified.

In December 2006, the Drug Control Department of the Government of the Republic of Lithuania together with the Public Health Institute of the Medical Department of Vilnius University and the Public Institution Training, Development and Research Centre carried out a survey on characteristics of people in maintenance methadone treatment. A targeted survey group included participants in the maintenance treatment programme throughout Lithuania. Sampling for the survey was based on the data from June 2006, meaning that 392 people participated in the maintenance treatment

programme. All patients receiving maintenance treatment programme services or those prescribed methadone during the survey period were asked if they would participate in the survey. In total 288 patients receiving methadone services agreed to answer the questionnaire and gave consent to the use of some data in their personal medical records. The biggest share (75%, n=217) of the participants in the maintenance treatment programme were treated in the centres for addictive disorders and 24% (n=71) in the mental health centres. Of those interviewed 76% (n=220) were men and 24% (n=68) were women. The average age of the surveyed participants on the maintenance treatment programme was 37.3 years, the most frequent age of the sampled patients (mode) was 43 years, half of those surveyed were younger than 38 years old, and the other half surveyed were older than 38 (median). The youngest participant in the programme was 20 years old and the eldest was 63.

Nearly two thirds of the patients (n=197) receiving maintenance methadone treatment had undergone treatment before for their dependence on drugs and psychotropic substances; another group (30%) stated that they had never been in treatment and 1% (n=4) did not answer this question.

The survey identified that 25% of the participants in the methadone programme have permanent jobs (n=71) or are registered with the labour exchange (n=70), around 20% (n=53) are unemployed, 18% (n=53) are disabled, 9% (n=25) have part-time jobs and 5% (n=14) are schoolchildren, retired, homemakers or another unemployed group. The data analysis by gender identified that a larger number of women have permanent jobs (28%) or part-time jobs (12%) compared to men (24% and 8%, respectively), and among men the number of unemployed (21%) and disabled (20%) was higher compared to women (12% and 13%, respectively). Though the employment results for the participants in the methadone programme depend on their present length of stay in the programme, the data show that more than half of the able-bodied patients did not work during the survey. This high unemployment level could be related to many factors, such as motivation, education or other external factors, such as stigmatisation and others. It can firmly be stated that the problem of unemployment among these patients should be addressed with some urgency.

All 288 participants in the methadone programme surveyed were treated for their dependence on opioids. Before treatment the biggest share of them (77%, n=223) used extract of poppies and a smaller share (22%, n=64) used heroin; 1 patient also declared the use of other opioids. The average age when the patients started to use these substances was 21 years; most frequently the first use of the main substance was at the age of 18 years (mode). Of the surveyed patients 97% (n=279) said that before treatment the main

pattern of use of drugs and psychotropic substances was by injection and 94% (n=270) indicated daily use of these substances.

The survey showed that nearly all (98%, n=283) were tested for HIV: 10% (n=29) were HIV-positive. Some (2%, n=5) of the patients said they had never been tested against HIV and the same percentage said they were tested but their infection status was not known.

The data show that the average participation time in the methadone programme was 49 months but the surveyed sample also included those participants who had been in treatment for around 30 months (mode). A good number of the participants in the methadone programme had been in treatment for 38 months while the others had been there for more than 38 months (median).

The doses of methadone were recorded in the accounting journal for all participants in the methadone programme and these were written into the questionnaires. The average methadone dose prescribed to a participant was 54.7 millilitres, the most frequent dose is 60 millilitres (mode), one cohort of participants were prescribed under 50 millilitres, and the other over 50 millilitres (median). The smallest prescribed dose was 10 millilitres, and the largest was 170 millilitres. Recommendations from the World Health Organization (WHO) regarding maintenance methadone treatment say the most effective methadone dose is between 60 and 80 millilitres. However, the survey data show that the average prescribed methadone dose was 55 millilitres. No correlation was identified between a methadone dose and use of illegal drugs and injecting while clinical research shows the contrary, a direct correlation.

The survey showed that 14% of the participants in the methadone programme had used additional drugs or psychotropic substances within the last 30 days and 12% injected within the same period. However, a longer period of participation in the programme reduces the risk of injecting drugs. Among the participants in the first year of the programme, 28% used additional drugs, among the participants who stayed in the programme for longer than one year only 10% used additional drugs and out of those in for a longer duration only 5% used any additional drug.

A high correlation exists between drug use and injecting, and positive urine tests regarding drug use may be used as an indicator to adjust treatment and in providing services. Optimal treatment results depend on sufficient duration of its application, its continuity and adequate doses of the pharmaceutical. Interventions targeted at prevention of relapse and/or risk behaviour can have a positive impact on HIV prevention as the data show that several HIV-positives demonstrate risk behaviour.

5.3 Treatment

5.3.1 Substitution treatment

In Lithuania, availability of substitution treatment is rather limited geographically. Lithuania is among the countries with limited application of such treatment as strict inclusion criteria are applied. Substitution methadone treatment is used only for treatment of opioid addiction. In Lithuania, the number of people registered as a result of their mental or behavioural disorders caused by opioids make up the major share of all registered for mental or behavioural disorders caused by drugs and psychotropic substances (approximately 78-80%). Treatment consists of the prescription of methadone solution taken under the observation of the medical personnel. Subject to approval of the medical examination commission, stable and socially adapted patients are usually allowed to take away a dose of medication for weekends or by visiting a health care institution two or three times a week. Patients in an unstable condition, who use illegal psychotropic substances, are required to visit a health care institution on a daily basis. Substitution methadone treatment is integrated within the treatment of all types of addiction conditions at the centres for addictive disorders and mental health centres. At the end of 2006, the methadone programme was conducted by the Vilnius Centre for Addictive Disorders and the mental health centres in the primary health care institutions in the City of Vilnius, the Klaipėda Centre for Addictive Disorders, the Kaunas Centre for Addictive Disorders and the mental health centres in the primary health care institutions in the town of Druskininkai.

The methadone programme for treatment of opioid addiction was started in September 1995. Prescription of substitution treatment and its implementation procedures are regulated by decrees of the Minister for Health issued in 1997 and 2002. Decree No. V-653 of 6 August 2007, of the Minister for Health of the Republic of Lithuania on Approval of Procedure Profiles Regarding Prescription and Application of Substitution Treatment against Opioid Dependence, and Prescription, Delivery, Keeping and Accounting of Substitution Opioid Pharmaceuticals in Health Care Institutions (Žin., 2007, No. 90-3587, effective from 7 September 2007) allowed the use of methadone hydrochloride and buprenorphine hydrochloride in Lithuania for substitution treatment and revised the requirements for substitution treatment. The aims of substitution treatment are as follows:

- to improve gradually the somatic and psychic condition of opioid addicts, their social adaptation and integration into society;
- to better organise prevention of HIV and hepatitis B and C, as well as other infectious diseases among drug users;
- to have more efficient treatment of correlate diseases;
- to have more efficient treatment of drug injection complications;

– to provide improved conditions for pre- and post-natal care of pregnant drug users.

In Lithuania, the process of maintenance methadone treatment continues to lack structure – whether methadone maintenance treatment is a service or a programme. Currently, the organisational and cost structure points to a mixed concept and this unclear concept may be deemed to be a disadvantage rather than an advantage. In future it will be necessary to put in place procedures regarding payment for maintenance treatment services to the medical institutions in order to encourage development of maintenance treatment services in all Lithuanian towns where needs for such services arise.

From 1 January 2006, methadone treatment was made available to 392 people. In 2006, methadone maintenance treatment was terminated by 143 individuals and started by 132. From 1 January 2007, methadone treatment was made available to 381 individuals, 90 (24%) women and 291 (76%) men. The age distribution of the participants in the maintenance methadone treatment was as follows: 1 person (0.3%) was under 20 years of age, 93 (24.4%) were in the 21-30 age-group, 126 (33.1%) were 31-40 years of age, 134 (35.2%) were 41-50 years of age, 23 (6%) were 51-60 years of age and 4 (1%) were over 60 years old.

Another medically assisted treatment – buprenorphine (Subutex) – was registered for treatment of opiate addiction in late 2002. Until 2005, buprenorphine was on the list of psychotropic medications and available at drugstores with a doctor's prescription. By order of the Minister for Health, buprenorphine became strictly controlled, meaning that the medication can now only be prescribed by mental health care institutions and consumed under observation of medical staff. The use of buprenorphine for substitution treatment of opiate addiction was validated from September 2007.

Naltrexone tablets (Revia), an antagonist of opiate receptors, was registered in Lithuania for treatment of opiate addiction in 2000. Naltrexone may be acquired by patients in drugstores with a doctor's prescription. The medication should be avoided during substitution treatment and prevention of relapses. The availability of treatment is restricted due to the relatively high price of the medication, which is not refunded by the state.

5.3.2 Drug-free treatment

In 2006, rehabilitation services for addicted people were provided in 16 long-term rehabilitation centres with 280 beds. The state budget provided financial support to the rehabilitation centres that are mainly private through projects. In 2005, 208 projects for rehabilitation services were allocated amounting to €2 000; in 2006 €225 470 were allocated and in 2007 this amounted to €220 690. In 2008, it is planned to provide around €290 000 from the state budget for rehabilitation projects. In 2006, financial support

was provided for 10 projects and on average this amounted to €22 000 per project.

For the implementation of state supported projects providing rehabilitation services, the biggest share (exceeding 70%) was allocated to cover the remuneration costs of professionals. This created prerequisites for receiving services of better quality and at lower cost, and these aspects are of particular importance to clients of the rehabilitation services. In 2005, financial support to cover salaries amounted to only 11%, while the biggest share of the allocation was used to cover other costs, mainly events and honorarium agreements. In 2006, with the help of the projects, psychological rehabilitation services were provided for 478 individuals dependent on psychoactive substances, including those in rehabilitation communities (426 people); assistance was also provided to 214 family members of dependent people.

In 2006, an efficiency evaluation of the rehabilitation process of people dependent on drugs and psychotropic substances was carried out. According to the data collected from the rehabilitation institutions, in 2006 a successful long-term rehabilitation programme was accomplished by 65 people the biggest share of whom (82%) were employed or educated. It was identified that in Lithuania up to 40% of people treated for drug dependency accomplish rehabilitation programmes successfully.

In recent years significant financial support for the rehabilitation of dependent people is provided by EU structural funds. In 2006, institutions providing rehabilitation services signed 13 agreements to obtain support amounting to over €3 million.

5.3.3 Dual diagnosis treatment

The data on dual diagnosis treatment for individuals with dependence on psychotropic substances has not been collected in Lithuania.

Since October 2008, with the introduction of monitoring of the individuals using drugs and psychotropic substances who contact health care institutions regarding mental and behavioural disorders, with reference to the monitoring procedures approved by Decree No. V-636 of 1 August 2007, of the Minister for Health (Žin., 2007, No. 88-3496), data on primary and dual diagnosis for individuals dependent on drugs and psychotropic substances will be collected.

5.3.4 In/outpatient treatment

In 2006, based on the data provided by the State Mental Health Centre, 14 606 individuals underwent treatment in inpatient institutions (contacted the inpatient institutions) while 3 034 individuals contacted outpatient health care institutions due to mental and behavioural disorders.

5.3.5 Drugs and/or alcohol and prescribed drugs

Services for individuals dependent on alcohol, drugs and psychotropic substances (F10.0 to F19.9 according to ICD-10) are provided in compliance with the Standards for Treatment and Rehabilitation of Dependence Disorders approved by Decree No. 204 of 3 May 2002 of the Minister for Health.

The services for treatment and rehabilitation of dependence disorders are provided at primary[4] and secondary[5] level. Some of them are commonly applied for individuals dependent on psychoactive substances (alcohol, drugs and psychotropic substances, etc.), at primary and secondary levels, including: examination and diagnosis by a psychiatrist; psychodiagnostic examination and counselling by a psychologist; counselling by a social worker; detoxification; maintenance treatment against dependence on alcohol (using naltrexone or disulfiram); maintenance treatment against dependence on opioids (using methadone or buprenorphine); non-specific treatment against dependence on psychoactive substance syndrome; and prevention of relapses. The services provided exclusively in specialised institutions (secondary level services) include short-term out- and inpatient psychotherapy rehabilitation programmes (following the Minnesota pattern), medium-term inpatient psychotherapy rehabilitation programmes, and long-term outpatient psychotherapy rehabilitation programmes, applied in the day centre and an inpatient institution. Further health care of such individuals is co-ordinated with the primary health-care specialists.

5.3.6 Availability/link to somatic and psychiatric treatment

Patients with dependence disorders that have developed severe abstinence induced delirium or psychosis caused by psychoactive substances undergo treatment in mental hospitals (nine mental hospitals in total).

Emergency medical assistance to patients dependent on psychoactive substances and those using psychoactive substances is ensured in all health care institutions as well as for all other patients.

General practitioners working in primary health care institutions in compliance with their medical competence are required to detect as early as possible any abuse of alcohol, drugs and psychotropic substances.

5.3.7 Rehabilitation services linked to treatment

Inpatient treatment and rehabilitation services for drug addicted individuals are provided by five centres for addictive disorders in Vilnius, Kaunas,

4. Mandatory health care in licensed mental health centres and outpatient units of the centres for addictive disorders.
5. Mandatory health care in licensed inpatient institutions for addictive and mental disorders, and their outpatient institutions.

Klaipėda, Šiauliai and Panevėžys. Inpatient treatment methods include short-term inpatient treatment following the Minnesota pattern lasting for four-six weeks, and medium- to long-term inpatient treatment (lasting up to 14 months) at a rehabilitation centre. These treatment programmes are based on the application of therapeutic community principles implying an active involvement of patients in the treatment and rehabilitation process.

5.3.8 Treatment of young people

Vilnius, Kaunas and Klaipėda addictive disorders centres provide special addictive disorders and rehabilitation services for children up to the age of 18 who are abusing alcohol, drugs, psychotropic or other mind influencing substances. These centres catering for special treatment for children and short-term rehabilitation offer 18 places for such children. In 2006, 29 children were cured.

The treatment period may last up to one month and include detoxification, treatment with pharmaceuticals and development of motivation. The rehabilitation services last from one-three months. A child who has undergone short-term rehabilitation should be provided with the opportunity to receive long-term rehabilitation services of adequate quality. Living in a rehabilitation community based on an approved programme and under the supervision of professionals, the child continues to learn and is assisted while developing social skills and self-esteem. The rehabilitation course may last up to 1.5 years. Currently, the only long-term public rehabilitation community institution, "Apsisprendimas", operates in the district of Ukmerge and its activities are co-funded by the state budget. The community may provide rehabilitation services for 12 children who have used drugs and undergone treatment for dependence. In 2008, it is planned to establish a state juvenile centre for psychological and social rehabilitation in Kaunas addictive disorder centre providing 10 places, so 40 places will be available in Lithuania for the psychological and social rehabilitation of addicted children.

5.4 Gender issues

5.4.1 Pregnant women/families with small children

No statistical data available.

5.4.2 Other gender issues

According to the data provided by the State Mental Health Centre, in 2006, of 5 573 individuals registered in the health care institutions as a result of mental and behavioural disorders caused by using drugs and psychotropic substances, women accounted for 18.7% and men for 81.3%. In 2006, of 68 951 individuals addicted to psychoactive substances there were 9 193 women (13.3%).

6 Special issues

The following areas may be mentioned: insufficient access to treatment services, underdeveloped maintenance treatment, no compensation for medication to addicted patients, limited scientific research in the field of treatment of dependence disorders and the need to develop methodologies for treatment of individual psychoactive substances (cannabis, amphetamine and cocaine in particular).

7 Strengths and weaknesses

7.1 Strengths

Following the approval of the Mental Health Strategy, a network of primary mental health care institutions in Lithuania developed and the specialised centres for addictive disorders were established. The State Mental Health Centre was established at the Ministry of Health as the institution co-ordinating primary mental health care at the national level. The legal basis for regulating treatment of dependence disorders was set up and standards for the treatment and rehabilitation of dependence disorders were developed, as were new procedures for maintenance treatment. The EMCDDA epidemiological treatment demand indicator is being implemented and treatment methodologies are being developed (for treatment of children in the primary health care institutions and treatment with opioid antagonists – naltrexone).

7.2 Weaknesses

There is insufficient tolerance by the public of patients with dependence disorders, and there is high stigmatisation of such patients and their families in society. The system for raising public awareness is underdeveloped and there is insufficient funding for the health care establishments and the resources required for the measures being implemented based on the public programmes.

8 References

8.1 Websites (French/English)

www.nkd.lt
www.sam.lt
www.aids.lt
http://profiles.emcdda.europa.eu/html.cfm/index19710EN.html
www.emcdda.europa.eu/html.cfm/index41330EN.html
www.emcdda.europa.eu/html.cfm/index41600EN.html

8.2 Organisations

Ministry of Health of the Republic of Lithuania
Drug Control Department under the Government of the Republic of Lithuania
Centres for Addictive Disorders
State Mental Health Centre

8.3 Literature

Drug Control Department of the Government of the Republic of Lithuania (2007). "Annual Report of the Drug Control Department of the Government of the Republic of Lithuania, 2007". Vilnius.

Poland

1 Demography

Poland is one of the biggest countries in Europe with an area of 312 679 square kilometres and a population of 38 125 479 people (as at 31 December 2006). The population density is 122 per square kilometre, with more than half of the population living in urban areas. The capital city is Warsaw with 1 702 139 inhabitants.

Of the total population, 7 660 567 (20.1%) fall within the age bracket 0-17 years old, 24 481 670 (64.2%) in the bracket 18-60/65 (female: 18-60, male 18-65) and 5 983 242 (15.7%) are retired.

Poland is in the process of strong economic development (gross national product (GNP) increased to 6.5% in 2007) but the unemployment rate is still relatively high – 11.5% in February 2008.

There are three administrative levels in Poland: the first level is the region (voivodship), the second one is the county and the third one is the community. On 1 January 2007, there were 16 regions (voivodships), 314 counties, 65 cities with county status and 2 478 communities in Poland. All three levels of administrative unit are self-governing. The local and regional authorities are in charge of most social and public health issues.

2 Epidemiology of drug use

The comparison of results of the general population survey from 2006 with the results obtained in 2002 made in relation to the population aged 16-54 basically shows a stabilisation in the prevalence of occasional drug use. The prevalence of current use of illicit drugs (in the last 12 months) for the population aged 16-54 does not exceed 3%. The results of the last countrywide school survey (ESPAD, 2007) in comparison with the previous one (ESPAD, 2003) suggests a decrease in the prevalence of drug use. The results of ESPAD 2003 show a 15% prevalence of current illicit substance use (in the last 12 months) among 15-16-year-old students, while in the ESPAD 2007 it fell to 11%. Among 17-18-year-old students the respective figures for 2003 and 2007 were 26% and 17%.

Among illicit substances, cannabis derivatives are most commonly used, both at experimental level as well as occasional use. Amphetamine and ecstasy use appear much less frequent and the remaining substances are used very rarely.

The occasional use of illicit substances is more common among males than females and it is most common in the age-group 16-24. It appears rarely among people aged 34-44 and is almost non-existent among people aged 45 or above.

Traditionally the major drug use problem in Poland centres around heroin. In the 1990s the availability of imported heroin increased and took over from home-made opiates known as "*kompot*" or "Polish heroin". In recent years the problem use of amphetamine has become more and more common. Multi-drug use has been a feature of the Polish drug scene for many years now. The last estimation of the number of problem drug users was made in 2005 with the use of the benchmark method within the framework of a country-wide population survey in 2006. According to the outcome of the study, it was estimated that there were 100 000-125 000 problem drug users in Poland in 2005. When this estimate is compared with an estimate done in the 2002, a significant increase is noted.

Information on the number of individuals treated for drug addiction in Poland is available from all inpatient psychiatric health services including specialised drug addiction treatment facilities. The data provides information on the diseases diagnosed according to the International Classification of Diseases 10 (ICD-10). Data from 2006 show that 13 198 people (34.9 per 100 000 population) were admitted to inpatient treatment facilities, among them 6 480 for the first time. In comparison to data from 2005 we can observe stabilisation, which can be considered a breakthrough with regard to the increasing trend noticed in Poland since the beginning of 1990s. In the case of first time admissions we observe a decrease by 8.4%. According to ICD-10 the diagnoses of the main clients of inpatient facilities are people addicted to opiates (17%), people abusing sedatives and tranquillisers (10%), amphetamine-type stimulants (8%), cannabis products (3%) and inhalants (1%). It is important to underline that 60% of people were classified as multi-drug users.

According to the latest drug prevalence estimates with the use of the benchmark method based on 2006, data on the number of problem drug users ranges between 100 000 and 125 000, including 25 000-29 000 addicted to opiates.

The National Institute of Hygiene collects data regarding the prevalence of HIV infection for the whole country from local laboratories. The incidence of new cases of HIV infection among injecting drug users in Poland is not increasing. Data on the number of new HIV cases among injecting drug users suggest a stability of trends during recent years whereas new infections among the general population appear to be increasing. However, a recent local study suggests a prevalence of 12.4% among a sample of 423 injecting drug users. No national data is available for hepatitis C and B infection rates

among injecting drug users in Poland. A cross-sectional study conducted in 2003 in the Śląskie and Lubuskie region and in the Warsaw district among injecting drug users in and out of treatment revealed prevalence rates for hepatitis C and B as 59.5% and 36.8% respectively.

Based on general mortality registers, the number of drug-related deaths seems to be rather low. There were 290 drug-related deaths noted in Poland (0.76 per 100 000 population). The number of drug-related deaths strongly fluctuates from year to year. Despite this factor some patterns have been detected. After an increase recorded in the second half of the 1990s deaths have levelled off between 2000 and 2005.

The mortality cohort study conducted with the use of longitudinal retrospective methods on patients of the residential treatment system 2000-2004 (observation period 2000-2006) shows 20 deaths per 1 000 persons. The mortality indicator shows a downward trend in 2000-2002 cohorts and it was slightly higher compared to 2003 and 2004 cohorts. The results of multivariate analyses indicate gender, age and time elapsed from the first episode in lifetime and weak treatment results as probable factors to the cause of the deaths.

3 Short history of drug treatment

The origins of treatment and rehabilitation of addicted people in Poland goes back to the first half of the 1970s although the government was not interested in providing any kind of help to drug dependent people at that time. Officially, the problem of drug dependency did not exist. Drug addicted people, if at all identified as such, could only benefit from the medical service of detoxification usually offered at psychiatric hospitals or, in cases of near death due to intoxication, at hospitals and clinics. The establishment of the residential centre for drug addicts was a real breakthrough in the approach to this phenomenon of drug addiction. In October 1978 a group of people addicted to Polish heroin, so-called "*kompot*", settled in a ruined and abandoned estate in Głosków near Warsaw. They were people who lived on the margins of society with no means to live and no future, who, together with Marek Kotański, a psychologist, left the psychiatric hospital. Kotański, who became the spiritual leader of the first therapeutic community for drug dependent people, proposed that they combine their efforts in the "fight" for their own lives and their future. That extraordinary community of people trying to find their own humanity was called "Monar". The Głosków programme was based on the principles of residents' self-management and self-control. The main principle of the code created by the patients themselves was total abstinence from drugs and alcohol. The method of help proposed by Kotański to drug dependent people had been inspired by the Synanon philosophy and practice, in spite of very limited access to American sources.

In 1981, young people appealed to the authorities to tackle the issue of drug use. In an open letter to the parliament, the Superior State Council and the Central Party Committee, which was published in the press, young people demanded that care services for drug dependent people based on the Głosków model should be established. Due to the pressure exerted by young people, teachers and parents, Monar – Youth Movement for Drug Prevention was established, which in October 1981 became officially registered as a legal entity and non-profit organisation.

During the 1980s, in different regions of Poland, other residential centres were established both by Monar and other organisations and institutions, including religious ones such as the Catholic community "Betania" and the Catholic anti-drug movement Karan. The latter is now the largest non-governmental Catholic organisation. The organisations listed above, and many others which address the issue of drug use, currently run residential centres for drug dependent people which are based on the therapeutic community model. However, drug rehabilitation clinics are increasingly referring to the Minnesota Model. They are also making use of behavioural and cognitive techniques such as life skills training and relapse prevention. The first decade of the 21st century witnessed the intensive development of residential and outpatient centres and consequently a higher number of places and financial resources. At present there are 80 drug treatment residential centres, 50 outpatient centres and 14 substitution treatment centres operating in Poland.

4 Organisation of treatment services

The legal basis for conducting drug treatment, rehabilitation and reintegration is laid down in the Act of Law of 29 July 2005 on Counteracting Drug Addiction (first legislative solutions date back to 1985). Drug rehabilitation is understood as a process in which a person with a drug-related mental disorder reaches an optimal health status, social and mental functioning. Drug rehabilitation may involve physicians, psychologists, drug therapists, health care units and non-governmental organisations.

Reintegration is understood mainly as providing psychological and welfare support for drug treatment graduates. It involves support groups, re-entry flats, hostels, night shelters and programmes to improve job qualifications.

Drug treatment may be provided exclusively by health care centres or individual/group medical practice centres. However, the core of drug treatment is constituted by specialist health care units for which problem drug users are the main target group. Among them 70% are made up by non-public health care units established by non-governmental organisations of which the highest number is operated by the Monar society. The remaining 30% are public health care centres established by local governments. Specialist

health care centres for drug addicts that guarantee 24-hour residential care are called drug treatment or rehabilitation centres.

As has been mentioned at the beginning, the rules of drug treatment and rehabilitation are laid down in the Act of Law on Counteracting Drug Addiction and the Act of Law on Health Care Units. Legislative solutions adopted in 1993, which place drug treatment centres in the health care system, ensure that the centres are mandated to observe rules pertaining to health care units. Considering the specific nature of drug treatment, these provisions apply in some areas to existing practice (for example self-help by patients is sanctioned: cleaning, cooking, etc.), and more liberal solutions were also adopted for instance in terms of living conditions and size of rooms.

In drug treatment and rehabilitation the principle of being attached to a specific geographical area does not apply. Consequently a problem drug user may be treated in any centre in the country regardless of his or her place of residence. Patients receiving treatment at health care units that have entered into a contract with the National Health Fund are not charged. In the case of uninsured patients the treatment is financed from the budget of the Ministry of Health. Drug treatment centres financed by the National Health Fund or the Ministry of Health (uninsured patients) must meet the criteria stipulated by the provisions of law. Treatment is voluntary. The exception is for patients under 18 that may be ordered to enter drug treatment following a decision of a court of law.

In 2002 a specialist training system in the field of drug addiction was implemented. It is obligatory for anyone who wants to work in drug therapy centres (drug rehabilitation clinics) regardless of the treatment model in place (therapeutic community, Minnesota programme, psychoanalytic approach or other). The training programme covers the core content approved by the Minister for Health. It covers four compulsory training components:

1. interpersonal and intra-psychical training;
2. lectures and workshops;
3. clinical internship in a recommended drug rehabilitation clinic that complies with specific quality criteria;
4. clinical supervision conducted by recommended supervisors.

Upon completion of all parts of the training course the participant takes a final exam that comprises a test, a case study and a presentation of a case before an exam panel. The training covers over 500 hours of classes and lasts approximately two years. There are two course profiles: drug therapy specialist and drug therapy instructor. In order to obtain a certificate to practice as a drug therapy specialist one must hold a medical school diploma or a higher education degree in psychology, pedagogy, social rehabilitation,

sociology, family studies or theology. In order to obtain a certificate to practice as a drug therapy instructor one must hold at least a certificate of secondary education and be a graduate of the above-mentioned specialist training programme. The National Bureau for Drug Prevention evaluates all training courses on a regular basis.

The available statistical data show that the current staff at rehabilitation centres is composed of 60% university graduates, 40% with secondary education and approximately 3-4% with just primary education. About half of them have completed or are completing specialist training. Many of them are ex-users. On average a drug rehabilitation centre employs nine specialists, which translates on average to one therapist per 10 patients.

5 Services

5.1 Detoxification

In Poland detoxification is provided within the hospital system. It is offered mainly to opiate users; however, amphetamine users are not uncommon. Only very few centres run outpatient detoxification programmes. Detoxification wards function mainly within psychiatric hospitals. In 2005, 23 detoxification wards provided detoxification with an overall number of 288 beds. When there are difficulties with access to a specialist detoxification ward, detoxification might be obtained in general psychiatric wards.

Detoxification wards vary in terms of detoxification methods and only a few offer detoxification with the use of methadone in gradually reducing doses. Detoxification usually lasts one to three weeks and is generally supported with counselling. Psychosocial interventions aim to raise the motivation of the patient to continue treatment. Detoxification is assumed to constitute a preliminary stage of the patient's stay at the inpatient rehabilitation clinic. In fact the patient's entry into detoxification is to start taking lower doses of the drug through lowering the tolerance level.

5.2 Evaluation/planning of treatment

Evaluation of treatment is the hot issue in Poland. The pilot project commissioned by the National Bureau for Drug Prevention has been sanctioned and will involve the development and testing of evaluation methodology as well as the setting up of a network of treatment facilities to conduct the evaluation.

The targeted system of treatment evaluation is based on a multi-stage design. Treatment will be evaluated on three levels: single cases (clients), treatment agencies and treatment system. In the first phase the focus is on outcome evaluation, then, in the second stage, process evaluation procedures will be developed as well.

The final model will consist of a network of treatment facilities conducting evaluations under the co-ordination and supervision of the National Bureau for Drug Prevention. There will be common work with strictly defined roles for each of the partners.

The National Bureau for Drug Prevention is responsible for providing research instruments, providing training, setting up databases, data processing and calculation of results, delivery of tables with results to treatment facilities, feedback on the reports prepared by treatment facilities, preparing reports at the national level and organising seminars.

The tasks for the treatment facilities will be data collection including follow-up data, data delivery in paper form to the National Bureau for Drug Prevention, data interpretation and preparing the report, including conclusions and recommendations, followed by the implementation of recommendations in practice.

The evaluation will cover the following types of treatment facilities:

– outpatient clinics
– rehabilitation centres
– substitution programmes.

The evaluation design will be based on a comparison of groups undergoing treatment. Clients from treatment facilities will form groups and basic socio-demographical characteristics will be controlled. All clients will be enrolled at the beginning and at the end of treatment, and a random sample will be recontacted (follow-up) 12 months and again 24 months after treatment is finished.

Dimensions which will be measured are as follow:

– socio-demographic data (gender, age, education);
– intervention characteristics (number of contacts, length of stay, programme finishing);
– substance use (types of substances, frequency, doses);
– risk behaviours (injecting, sexual);
– health (physical, psychological – frequency of major symptoms);
– social functioning (employment, relationships with relatives and friends, crime – drug-related and other).

The following research instruments will be used:

– standardised questionnaire – Maudsley Addiction Profile (MAP) – validated in Poland on the small-scale sample;
– additional questionnaire with country specific supplementary information;

– form for data from patients' files (socio-demographic, initial assessment, basic parameters of treatment received).

The MAP will be used for each measurement. The additional questionnaire will be used in modified version.

Analysed data will include comparisons of changes over time in substance use, risk behaviours, health status and social functioning treated as a measure of success. Basic treatment characteristics will also be considered as factors, and socio-demographic characteristics as control variables. Multifactorial models will be developed for this purpose.

The participation of each client in the evaluation exercise is on a voluntary basis. An informed consent form including consent to follow-up will be used. A special procedure for follow-up contact to maintain confidentiality will be developed. Data protection measures will be assured using ID codes – the full names will be never be sent to the National Bureau for Drug Prevention. Results and conclusions will be discussed with all stakeholders.

The pilot project covers 12 treatment facilities:

– six residential rehabilitation centres
– four outpatient clinics
– two substitution programmes.

The objective of the study is to test research instruments and data collection procedures. If data collection goes well, the first results will be available soon. The experiences collected up to now on a pilot level are as follows:

– the proposal to participate in the pilot study was met with enthusiasm from the treatment facilities – there were no problems with recruitment;
– data collection is not a significant burden to treatment staff;
– clients did not complain about the study;
– no client has refused to participate up till now;
– the data collection did not disturb the treatment process.

5.3 Treatment

In Poland the majority of residential drug treatment and rehabilitation centres operate as therapeutic communities. Treatment in a community lasts between six and 14 months although longer programmes (up to two years) still exist. The goals of treatment in a therapeutic community are considered at two levels: psychological and social. The aim of the therapy from a psychological aspect is to develop a new identity for the user through changing patterns of thinking, feeling and behaving that predispose to drug use. With respect to the ability to function socially the emphasis is placed on developing responsibility and a drug-free lifestyle. Successful integration of changes in psychological and social aspects is a prerequisite for recovery.

The structure of therapeutic communities for drug addicts is of a hierarchical character. The position of a community resident depends mainly on the time spent in the community and the progress in taking up responsible roles. Meetings of the therapeutic community remain the most important component of the programme apart from individual and group therapy, skill training, sports, art activities and therapy through work. The centres also offer the opportunity to continue or extend education (up to 18 years of age it is compulsory and free of charge), as well as the opportunity to get additional vocational qualifications. At present, programmes co-financed from EU resources offer great vocational training opportunities for addicts.

In recent years a number of drug rehabilitation centres extended their therapeutic provision with methods originating in the so-called cognitive-behavioural Minnesota Model and the relapse prevention concept.

Increasingly, more centres are introducing individual treatment plans in order to individualise the approach to the patient's problems. This approach provides the opportunity to better adapt the aid strategy to the needs and capacities of patients.

According to law, a rehabilitation clinic is obliged to provide medical care. As such every centre employs a medical doctor (most often on a part-time basis). HIV patients stay under specialist care provided by hospitals and infectious disease centres that co-operate with drug treatment centres. Some of these patients enter Highly Active Antiretroviral Therapy (HAART therapy).

It is worth stressing that the majority of rehabilitation centres offer their graduates places in hostels or re-entry flats.

5.3.1 In/outpatient treatment

For a number of years we have observed a lack of balance between the development of inpatient and outpatient treatment centres in Poland, placing the latter at a disadvantage. Some changes in this respect only took place in the year 2000, when the number of outpatient clinics and the number of clients admitted thereto started to rise noticeably. Instead of opiate users there were increasingly more problem amphetamine users entering treatment. The largest age-group in outpatient treatment is the 18-29-year-old group. The therapy goals fall into the following categories: abstinence, change of drug use pattern, improvement of quality of life. The outpatient treatment offers counselling, critical intervention and motivational interviewing. Unfortunately, outpatient clinics do limit their referral of patients to inpatient clinics and help in finding a place. Fortunately, increasingly more outpatient clinics are trying to develop a more comprehensive provision involving a long-term care programme that uses the cognitive-behavioural model.

The results of the 2006 study commissioned by the National Bureau for Drug Prevention show that outpatient clinics do not devote enough attention to post-rehabilitation in the form of help to resume education (only 32% of centres), finding a job (29% of centres) or finding a flat (only 18% of centres).

At present drug rehabilitation centres offer 2 500 beds, which gives a rate of 7 beds per 100 000 inhabitants. Annually approximately 7 500 patients go through the inpatient treatment system. The biggest group is made up of patients aged 16-24. Another large group is patients aged 25-34. Patients in treatment are addicted mainly to opiates and amphetamine and the majority of them are poly-drug users. The capacity of centres varies. Most often they house 25-40 beds, but larger centres also exist.

5.3.2 Substitution treatment

The availability of substitution treatment in Poland does not meet current needs. The previous policy in terms of promoting substitution treatment and establishing new programmes proved only partially successful. Although it is true that the first programme was set up as early as 1993 the new ones had to fight for their survival. Up to 2005 only public health care units with the approval of the provincial governor and the positive opinion of the Minister for Health were entitled to provide substitution treatment. In 2005 new regulations entered into force. They entitled not only public but also non-public health care units to run such programmes. But every substitution treatment programme still must obtain the approval of the governor. It seems that enlarging the group of institutions entitled to run substitution therapy has brought positive results. After a few years of stagnation, in 2006 three new programmes started offering services for 250 patients.

An obligatory component of substitution therapy is the psychosocial support of at least two hours a week. Qualification criteria for a substitution treatment programme include being at least 18 years old, with at least three years of opiate use and three unsuccessful conventional treatment attempts. The substitution treatment programme manager may under exceptional circumstances admit people who do not qualify for the programme where their health status is an important indicator for substitution treatment.

At present there are 14 substitution treatment centres operating in Poland. They provide services for 1 450 patients, which amounts to not more than 4% of all opiate addicts. In 2002, substitution treatment programmes were introduced in penal institutions; however, they involve only 40 inmates. Substitution treatment is free of charge for addicts and it is financed by the National Health Fund. Methadone remains the only substitute drug applied in treatment.

5.3.3 Dual diagnosis

Some drug rehabilitation clinics specialise in co-morbidity therapy. The first one was established by the Familia Association in 1998. Since that time a few new specialist entities have been set up. However, the number of centres specialising in this type of therapy is insufficient despite the fact that dual diagnosis is made relatively seldom in Poland (in about 8% of drug users in treatment).

5.3.4 Treatment of young people

A therapeutic community for adolescents and young people is the oldest described, tested and implemented concept of work with young people in Poland and also worldwide. In 1983 the first rehabilitation centre based on this method was established in Gdańsk. It was the first specialist programme for adolescents and young people which applied the therapeutic community method as the main way of therapeutic and correction intervention in Poland. The "Find yourself" therapeutic programme at the Gdańsk centre was described following external professional evaluation as one of the most promising therapeutic programmes for adolescents and young people in the world. Today, the Gdańsk centre is a model community of how to work with minors. Apart from the classical principles and main philosophy of the therapeutic community, the young community includes a number of structural and methodological solutions which allow one to adapt it not only to age but predominantly to the developmental needs of young people. For young people on drugs this became a way of life, it solved all problems, filled the void, and helped them escape from the world and their incompetence and to cope with life. In therapeutic communities for youngsters the following therapeutic factors are especially crucial: responsibility for their own behaviour, adopting positive values, positive peer pressure, learning through copying and following good examples as well as improving self-esteem through creative and intensive participation in community life and clearly set principles and requirements.

Through a wide range of forms of work with young people, from diverse psycho-correctional methods to manual activities enabling creativity and personal development, the programme does not only treat children but also favours their development. Every centre has its specificity and its own style of therapeutic work.

In Poland there are currently 17 therapeutic communities for young people with a total of 600 residential places. The programme of residential treatment normally lasts from 6 to 12 months. In all residential centres there is an obligation to continue school education and this is provided outside the centre. Young people aged 13-21 with diagnosed addiction or harmful abuse of drugs are admitted to the residential programme.

Besides residential centres in Poland there are counselling services for children and young people, as well as for their parents and legal guardians, which offer a wide range of help from family counselling through short-term treatment, motivational treatment, family treatment and personal development to task groups, psycho-education, self-help groups and critical intervention. In the majority of counselling centres it is also possible to benefit from early intervention, undergo drug tests or take part in prevention initiatives. Participation in all therapeutic programmes in the case of minors is possible only with parental approval.

A relatively new proposal in the therapy of children and young people who harmfully abuse psychoactive substances are day care centres in which apart from therapeutic assistance (individual short-term treatment, therapeutic groups, counselling), the aim is for personal development and active help in school education. Currently there are 10 such centres in the major Polish cities.

5.4 Gender issues

In the Polish treatment and rehabilitation system there are no therapeutic programmes targeting one specific gender. In all counselling and residential centres standard services are offered both to men and women. In some of the outpatient centres gender-oriented programmes are conducted, for example group meetings for addicted pregnant women, group therapy for girls with co-occurring disorders (e.g. anorexia or bulimia) as well as groups for co-addicted women and women victims of violence. At the outpatient centres women may benefit from health counselling and referral to specialist health care services. Residential centres are co-educational.

In the framework of the programme of these centres in some of the cities, special programmes addressing women are conducted, for example “Your style”, “How to be a couple”, “Conscious motherhood” or “Be a woman”. Normally women who stay in the rehabilitation centres together with their children are obliged to participate in programmes for mothers. They live in separate parts of the rehabilitation centre building. According to professionals the most effective residential therapeutic programmes are integrated communities resembling natural social settings accepting the co-existence of both genders.

5.5 Treatment within the criminal system

The prison population varies greatly. According to the principle of an individual approach to executing the penalty of deprivation of liberty a number of inmates are offered specialist therapeutic interventions. It particularly concerns addicted prisoners, patients with non-psychotic mental disorders,

mentally disabled patients and people diagnosed with sexual preference disorders.

The following principles are respected in therapeutic wards: the superiority of therapeutic interventions over other kinds of penal intervention, the collective nature of therapeutic interventions, the integration of therapeutic interventions into other forms of intervention performed in the penal institution and interventions based on individual therapies.

At present there are 14 therapeutic wards for inmates addicted to narcotic drugs or psychotropic substances. They offer 512 beds and 1 502 addicted inmates entered treatment in 2006. The therapy lasts six months and takes the form of both group and individual psychotherapy based on a cognitive-behavioural model, which aims at teaching various skills relating to maintaining abstinence and getting satisfaction out of life. The therapy aims to work on cognitive disturbances which seriously prevent patients from changing their destructive behaviour. No pharmacotherapy is applied in drug treatment. Programmes in therapeutic wards under the Polish penal system are similar to programmes at rehabilitation clinics outside the prisons. Despite taking all the above steps, the number of rehabilitation wards in the prison service is insufficient and not all inmates can be admitted to the specialised units. The waiting time for admission is a few months. Apart from therapeutic activity, penal institutions run a number of secondary prevention programmes. In 2007, approximately 111 programmes of this sort were conducted and they involved 4 100 inmates. There are also programmes aimed at health promotion, sexual education and HIV/Aids. A number of penal institutions co-operate with the Narcotics Anonymous community and its members take an active part in prison meetings.

6 Special issues

6.1 Standards and accreditation of treatment and rehabilitation centres

In recent years much more attention has been paid to the conditions for providing treatment services and their proper standards. This process has been taking place in the course of a number of discussions and ongoing changes in the provisions of law. In this context in 2004, the Ministry of Health ordered a team of drug therapy specialists to develop a set of standards and an accreditation system for drug and alcohol therapy centres. The team created a document that lists standards of care for the patient and management functions in residential drug rehabilitation facilities, as well as in outpatient clinics. They cover such issues as: patients' rights, continuity of treatment (e.g. standards of admission to a centre, transferring a patient to another centre, criteria for admission denial, standards of release from treatment, conduct procedures in the case of a patient's absence without official leave,

etc.), as well as standards of care (evaluation procedures, psychotherapeutic conduct procedures, individual treatment plans, etc.). In the field of management the standards concern the organisational structure, staff training, documentation storage, staff qualifications, etc. It must be stated that the proposed standards in the field of care for the patient do not impose the implementation of solutions but rather verify whether the centre procedures are compliant with the law and knowledge on effective treatment. In connection with the new standards a set of assumptions for the accreditation system for rehabilitation centres was prepared and full implementation was planned for 2008. It is thought that accreditation will be valid for three years and a centre will have to apply for renewal of accreditation. Undergoing accreditation will be voluntary. However, considering the organisation of the drug treatment system one must expect that the centres will be really interested in obtaining accreditation because it will result in greater chances of obtaining financial resources from the National Health Fund. Moreover, it must be stressed that although the system of standards and accreditation procedures were developed by order of the Minister of Health they were developed by drug therapy experts. This is the reason why they are more likely to be accepted by the whole community of drug therapists.

6.2 Clients' rights

The question of patients' rights has been given high priority in recent years in Poland within the whole system of health care. These aspects are regulated by separate provisions pursuant to the Act of Law on Health Care Units, the Act of Law on the Medical Profession and the Act of Law on Mental Health Care. The last act of law is of special importance especially in the context of patients' rights in a rehabilitation clinic. Patients' rights refer to a great number of issues, such as providing assistance to patients according to the current state of knowledge, in rooms and conditions that comply with specific sanitary provisions; recognising and treating them according to ethical work principles and with due diligence; providing them with living conditions and diet corresponding to their state of health; giving them religious assistance, obtaining information for the patient as they should be able to have access to the evaluation of their state of health; proposing evaluation, treatment and rehabilitation methods; ensuring the right to unlimited personal contact, on the telephone or by post with people from outside; and providing data protection for the medical records of a patient. Only a few issues that directly concern patients' rights have been mentioned here. The Spokesperson for Patients' Rights was appointed by the Minister for Health and deals with complaints in relation to violations of patients' rights. He/she also accepts complaints from rehabilitation clinics. The issue of observing patients' rights in rehabilitation clinics for under-age drug addicts was of particular interest to the ombudsperson. The visit results showed that the most problematic issues concerned school obligations for the clinic residents,

limitation of contact with family at the first stage of treatment and lack of information about patients' rights that would normally be available to all patients. From the perspective of recent years it may be concluded that the awareness of patients' rights among the therapeutic personnel and the patients is increasing rapidly, which results in fewer cases of rights violation.

7 Strengths and weaknesses

Drug treatment and rehabilitation centres have gone through a lot of changes in recent years. Establishing the first therapeutic communities in 1978 and the beginning of the 1980s laid the foundations for the establishment of an original system of assistance to addicts, a system which would be independent, in its concept, from psychiatry. In the years that followed there were attempts to look for better solutions and compromises between the provisions of law and the specific nature of drug treatment.

In the second half of the 1990s important changes were introduced in terms of financing drug therapy (through the National Health Fund), which resulted in a greater concern over the standards of service but also discussion concerning the integrity of the system and the drug therapy concept. The community of drug therapists has voiced their concerns a number of times on whether changing the system would keep to the spirit of treating drug addicts. The practice has shown that it is possible.

The year 2002 brought further changes and the introduction of the compulsory system of training for drug therapists. The system of training is first of all an effective instrument to raise the qualifications of people providing assistance to drug addicts. Apart from this basic function, the system of training also has a vital influence on building a professional ethos and increasing the prestige of this professional group. Further actions of the community of addiction therapists and health care managers should focus on finalising standards and the accreditation process.

A key issue is promoting the evaluation practices among the staff of drug rehabilitation clinics, including making use of the knowledge gained and drawing conclusions from the research.

Despite the above positive changes there is some room for improvement in the care of drug addicts. In Poland it seems that we can see some kind of imbalance in the availability of different services for drug addicts. In particular this concerns substitution treatment which needs further development. Moreover, the scope of services offered by inpatient clinics requires more variation and development of a more comprehensive approach. In the context of discussions on drug rehabilitation clinics one must remember that providing complex care for problem drug patients requires the development of other forms of assistance: outpatient clinics, substitution treatment centres, needle and syringe exchange programmes, night shelters and others.

Only then will the health care system be able to effectively meet the various needs of patients.

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Russian Federation

1 Epidemiology of drug use

In 2006, 2 185 200 alcoholics were registered in the Russian Federation, or 1 530.75 per 100 000 of the population. This indicator is lower than the figures for 2005 (2 215 372 and 1 560.54 respectively), 2004 (2 233 515 and 1 565.29) and 2003 (2 226 430 and 1 552.03).

In 2006, 350 000 drug addicts were registered, or 245.4 per 100 000 of the population, showing a slight increase (1.4%) on the 2005 figure. The average year-on-year increase for this indicator in the last five years stands at 1.2%, pointing to its stabilisation. The breakdown of patient profiles remains virtually unchanged: the overwhelming majority suffer from opiate addiction (87.7%), with cannabis addicts in second place (6.4%). The proportion of those dependent on psycho-stimulants is small – barely 1.6%.

The indicator showing the extent of use of harmful drugs stood at 117.4 per 100 000 in 2006, an increase of 6.1% on the previous year. The total number of drug users (including drug addicts and users of harmful drugs) was 517 800, or 362.8 per 100 000 of the population. Of the total number of registered drugs users, 367 300 or 70.9% injected drugs.

Of the total number of registered injecting users of drugs, 11.8% were infected with HIV (compared with 9.3% in 2005). An HIV-infection level of over 5% among registered injecting drug users was recorded in 47 regions (37 in 2005), which is over half the Russian Federation's constituent entities (59%). The research figures for injecting drug users hospitalised in drug dependency day-and-night clinics in seven constituent entities of the Russian Federation in 2006 show that 80% of them were infected with hepatitis C.

The mortality rate among drug addicts under medical supervision in 2005-2006 was between 2.0 and 2.3 deaths per 100 patients of the annual average contingent.

2 Short history of drug treatment

The medicinal therapy of alcoholism and drug addiction in the Russian Federation was placed on a scientific footing and properly organised in the late 1930s and early 1940s. From then onwards and up to the mid-1980s treatment programmes were dominated by conditioned response therapy for alcoholism and atropine coma therapy for drug addictions involving the opiate group. These methods suffered from substantial drawbacks: they were difficult to manage, required substantial efforts and were regarded in negative terms by patients and staff. From the mid-1980s up to the present

day psychopharmacotherapy has predominated in the treatment of these illnesses. It called for a detailed psychopathological analysis of the clinical manifestations of alcoholism and drug addiction in order to determine "targets" for the different psychotropic preparations. These include pathological urges for alcohol and drugs, affective disorders, impairment of intellect or memory, personality disorders and the numerous variants and sub-variants of above.

A range of antidepressants, tranquillisers, nootropics and normotic-effect anticonvulsants are used as medicinal treatment. Opiate receptor blockers, neuropeptides and other drugs are used in combination with them. The ultimate aim of medicinal treatment is to create a stable basis for psychotherapy, support work and sociotherapy.

The treatment programme as a whole consists of detoxification (introduction of polyion complexes, vitamins, plasmapheresis, other non-medicinal methods), restoration of impaired functions (neurosomatic, mental functions), suppression and prevention of relapses of pathological urges for psychoactive substances, and treatment of concomitant diseases, in particular combinations of drug-related and other mental illnesses (dual diagnosis).

3 Organisation of treatment services

Drug dependency clinics are headed by a chief doctor, who is at the same time the chief drug dependency specialist (chief specialist in the treatment and prevention of pathological dependency) of the corresponding territory. The chief drug dependency specialist's tasks include ensuring interaction between the drugs dependency service and the other departments and services when their input is required.

Decisive steps are now being taken in further vocational training, in particular the provision of psychiatric qualifications for psychiatric doctors specialising in drug dependency. From now on, these posts are open only to doctors who have undergone internship training in psychiatry and possess the corresponding diploma.

In 2006 an increase was recorded in the number of psychiatric doctors specialising in drug dependency, with a rise in the proportion of specialists in the highest qualified category and also doctors possessing the corresponding diploma. The qualification categories for psychiatric doctors specialising in drug dependency are as follows for 2006: 902 doctors possessed the highest category of qualification (15.4%), 1 114 (19.0%) had category one qualifications and 578 (9.8%) category two qualifications. At the same time 55.8% did not have any qualifications in these categories, which points to the need to carry on focusing on the vocational development of staff. Table 3 provides data on psychiatric doctors specialising in drug dependency.

Table 3: Data on psychiatric doctors

	2000	2001	2002	2003	2004	2005	2006
Number of psychiatric doctors specialising in drug dependency	5 284	5 505	5 648	5 759	5 888	5 882	5 875
Per 10 000 of population	0.37	0.38	0.40	0.40	0.41	0.41	0.41
Number of posts held	7 137	7 504	7 905	8 299	8 562	8 603	8 713
Per 10 000 of population	0.49	0.52	0.55	0.58	0.60	0.60	0.61

This table shows that the number of doctors' posts provided in the drug dependency service is higher than the number of doctors holding such posts. However, the number of doctors is rapidly growing.

4 Services

The system for treating alcoholism and drug addictions in the Russian Federation is based on a clear understanding of the fact that the dependency illnesses, to which alcoholism and drug addiction belong, are mental illnesses. This is made absolutely clear in the International Classification of Diseases (ICD-10). As the number of those suffering from alcoholism and drug addictions within the population is far higher than those suffering from other mental illnesses and the damage caused to society and the country is enormous, the treatment and prevention of dependency illnesses have made it necessary to devise quite specific approaches providing for the broad participation of the state in resolving the problem. Accordingly, it is the state health authorities that handle the treatment and prevention of alcoholism and drug addictions in conjunction with other, non-medical, departments and services. This does not rule out the involvement of non-governmental organisations and institutions; on the contrary, this is encouraged.

With all due respect for the rights and freedoms of the individual, the view that alcoholism and drug addiction are a lifestyle choice and a matter of taste, and not an illness, is considered as wrong in Russia. It is a hindrance to meaningful and comprehensive programmes designed to solve the problem and contrary to scientific findings.

In 1976 a drug dependency service was set up as part of the health protection authorities by government decision. It was set the tasks of detecting, recording, treating and preventing alcoholism and drug addiction. The principle of medical surveillance, that is, active supervision and treatment, was established as the basis of treatment and prevention work with patients.

The entire operational staff contingent was split into groups corresponding to the clinical state of patients and requiring a differentiated approach.

The basic structural element of the drug dependency service is the drug dependency centre. These centres were set up in every region of the country and in all large cities. Each clinic has offices for substance abuse counsellors, their number being defined in relation to local population size or the size of the territory covered.

All substance abuse counselling offices are staffed by a psychiatric doctor specialising in drug dependency and middle-grade medical staff (nurses, doctor's assistants). They are located either on the premises of the clinic or more broadly within general medical establishments (polyclinics and hospitals). In the latter case the counselling office is under dual management: all guidance on methodological aspects comes from the drug dependency centre (introduction of treatment programmes, carrying out of preventive measures, epidemiological surveys, structured recording of patients, interdepartmental co-operation in identifying patients and enrolling them for treatment, health promotion in schools and companies, producing reports for statistical analysis, etc.). Administrative management (work organisation charts, laboratory research, consultation with specialists in other disciplines, material support, etc.) lies within the competence of the general hospital establishment.

A ramified service operating across the board requires a large number of psychiatric doctors specialising in drug dependency: there were 5 284 in 2000, with the figure subsequently rising to 5 505 in 2001, 5 648 in 2002, 5 759 in 2003, 5 888 in 2004 and 5 882 in 2005. The reason for this strong growth in numbers was the retraining of doctors with other specialities, attracted by substantial benefits (such as increased pay and more annual leave). But as a result of this extensive recruitment, the professional standard of psychiatric doctors specialising in drug dependency was not high enough, which was an obstacle to the necessary personalisation of and differentiated approach to treatment and led to a decline in the authority and reputation of doctors in the eyes of the public and the patients.

The democratic reforms in Russia in recent years were accompanied by a partial reform of the drug dependency service, which took on a more humanistic approach. At present, drug dependency centres have the tasks of ensuring continuity of treatment for patients discharged from other treatment establishments, including private establishments; psychotherapy and support work with patients' families; participation in the activities of public psychotherapy groups and communities; and preventive work with individuals abusing alcohol and drugs. They also work with other (state and private-sector) organisations and services with the aim of providing assistance and support for patients who are receiving treatment or have

undergone a treatment programme and are in remission, to help them, for example, find work, resolve housing problems or receive benefits.

Early detection, registration, recording and treatment of patients remain the most important functions of drug dependency centres, although they are carried out only with the patient's consent, namely, on a voluntary basis. In exchange, to make the state drug dependency service more attractive, patients enjoy certain privileges: they are treated free of charge and do not have to queue. This is a considerable advantage in today's conditions for certain patients not wishing to receive treatment following the usual rules, and treatment is also available on a paid-for basis in private clinics. In addition, these patients may opt for treatment on an anonymous basis. Nevertheless, they are included in the statistical indicators of the state drug dependency records. These indicators, together with information from other departments (crime, accidents, etc.), are used for annual monitoring of the drugs situation, which is another task of the drug dependency centres.

To carry out their functions, drug dependency centres incorporate surgeries for work with young people, offices for psychologists, social workers, psychotherapists and consultant doctors and facilities for anonymous treatment, expert appraisals and prevention work (health promotion, work in schools, companies, etc.). Drug dependency centres have a consultation room with a helpline for working with the local community.

The development of the network of establishments run by the drug dependency service over the last six years is shown in Table 4 below:

Table 4: Outpatient network of the drug dependency service

	2000	2001	2002	2003	2004	2005	2006
Drug dependency centres	203	205	200	194	191	182	162
Drug dependency offices	2 000	2 060	2 006	2 007	1 989	1 975	No data
Surgeries working with young people	256	288	308	332	338	350	No data
Facilities for expert appraisals relating to alcohol intoxication	280	250	274	297	311	346	No data

This table shows that, as the result of a change in the nature of the drug dependency service activities, there has been a certain reduction in the number of its establishments, particularly in the last two years. At the same time, the number of surgeries working with young people has expanded, from 256 in 2000 to 350 in 2006. The same applies to the facilities for expert appraisals.

Drug dependency centres have a clinic with a number of beds reflecting the size of the population of the territory covered (the total number of beds for the clinical treatment of patients with dependencies in the Russian Federation stood at 29 628 in 2001, a figure which fell to 28 200 by 2005). One of the clinic's sections has the role of providing urgent medical assistance for patients in a severely intoxicated state, with heavy withdrawal symptoms and displaying psychotic disturbances.

Where necessary, to tailor the treatment process more closely to the patient's circumstances, day- or night-patient treatment is used, in day-and-night clinics incorporated into the centre. Patients receiving day-treatment go home at night, while the night-patients work during the day and come into the clinic in the evening to receive the necessary treatment and remain under medical supervision for the night. Depending on the patient's clinical state (presence or absence of pathological urges for alcohol or drugs, affective disorders, dormant state, cognitive functions), assessed by a psychiatric doctor specialising in drug dependency, the patient may be transferred to a normal clinic or an outpatient facility, or discharged to go home. Day- or night-patient treatment may also be an intermediate stage between the clinic and discharge, serving to rehabilitate patients.

Data on the network of clinical establishments of the drug dependency service are shown in Tables 5, 6 and 7.

The number of drug dependency hospitals rose from 11 in 2000 to 15 in 2004, falling back to 14 in 2005 (Table 5). The provision of drug dependency beds showed an insignificant drop from 2.2 per 100 000 of the population in 2000 to 2.0 in 2006. The number of clinical departments in drug dependency centres fell from year to year from 162 in 2000 to 133 in 2006. The total number of beds fell by 1 020 beds (3.5%) between 2000 and 2006, to 27 900. Despite something of a drop in the provision of beds, the hospitalisation of patients with mental and behavioural disorders caused by the consumption of alcohol, drugs and non-narcotic psychoactive substances rose by 10% over the same period.

Table 5: Clinical network of the drug dependency service

	2000	2001	2002	2003	2004	2005	2006
Number of large drug dependency clinics	11	10	13	15	15	14	14
Number of drug dependency beds	28 901	29 628	29 294	28 823	28 759	28 266	27 881
Per 100 000 of the population	2.2	2.2	2.2	2.2	2.1	2.0	2.0
Occupancy of drug dependency beds (days in year).	306.6	297	303	309.3	311	314	314.3

In 2006, 707 000 patients were hospitalised (652 300 in 2000). The increase in the total number of hospitalisations for the period 2000-2006 was due solely to the increase in the hospitalisation of patients suffering from alcoholism from 247.8 per 100 000 of the population to 304.8 (up by 23%), particularly patients with alcohol-related psychoses, up from 99.9 cases per 100 000 in 2000 to 105.2 in 2006 (plus 5.3%). The hospitalisation of patients with alcohol-related psychoses was particularly high in 2003, with 123.4 cases per 100 000 of the population. This was the highest ever number of such cases recorded in the existence of the drug dependency service, pointing to an extreme worsening of the alcohol situation in Russia (see Table 6). It is true that from 2004 to 2006 the figures were somewhat lower in comparison with 2003 but they nevertheless remain extremely high.

The level of hospitalisation of patients with drug addictions in 2006 showed a fall of 24.7 compared with 2000, from 82.4 to 62.1 per 100 000 of population. There was a sharp drop towards 2002, when 27.3 patients per 100 000 of population were treated in clinics. The causes of such a sharp drop remain unclear but the fact itself was proven in different regions of the country and is in line with the data on the number of people who received treatment in relation to narcotic drugs poisoning in toxicological centres throughout the country. The increase of hospitalisation of patients began in 2003 (+8.5%), in 2004 (+24.7%) and in 2005 (+32.3%), with a further increase of 27.5% in 2006 making it a constant increase over the last four years. The rise in the number of hospitalisations from 2003 to 2006 was basically down to patients with opiate addictions, up by 9.5% in 2003, 25.3% in 2004, 34.4% in 2005 and 28.4% in 2006. The level of hospitalisation of patients with other forms of dependency (cannabinoids, cocaine and other psychostimulators) and also with dependency on non-narcotic psychoactive substances has fallen in the last three years.

Table 6: Hospitalisation of drug-dependent patients

	2000	2001	2002	2003	2004	2005	2006
All patients (expressed in 1 000s)	656.3	682.5	684.7	695.7	707.2	717.7	707.6
Per 100 000 of population	450.9	470.9	474.7	484.8	495.6	505.6	495.7
Alcohol-related psychoses	99.9	112.3	122.9	123.4	120.6	115.7	105.2
Alcoholism (without psychosis)	297.8	270.6	301.0	310.6	314.6	314.5	304.8
Psychoses in drug addicts	1.16	0.99	0.60	0.48	0.50	0.55	0.6
Drug addictions	82.4	63.9	27.3	29.5	36.8	48.7	62.1
Of which opiate-related	80.2	61.9	25.2	27.6	34.6	46.5	59.7

The average length of stay in a clinic for patients with drug-related disorders has been falling each year for the last six years: it was 17.2 days in

2000 and totalled 15.1 days in 2006 (see Table 7). Above all, it was the duration of inpatient treatment for patients suffering from alcoholism that decreased, from 19 days in 2000 to 15 days in 2006. This may point to an unjustified shortening of treatment programmes. The length of stay in a clinic for patients with drug addictions was also rather short and fell from 2002 onwards, from 16.8 days in 2002 to 13.2 in 2006 (13.9 days in 2000).

Table 7: Average length of stay in a clinic for patients with drug-related disorders

	2000	2001	2002	2003	2004	2005	2006
Total	17.2	16.5	16.4	16.0	15.7	15.2	15.1
Alcohol-related psychoses	17.7	17.2	17.1	17.2	17.7	17.5	18.0
Alcoholism (without psychosis)	19.0	17.2	16.6	16.0	15.6	15.1	15.0
Psychoses in drug addicts	18.2	20.8	21.4	24.6	19.2	18.9	15.7
Drug addictions	13.9	15.3	16.8	15.5	14.5	13.7	13.2

One special means of rehabilitation is provided by the various workshops (needlework, joinery, art, etc.) available within drug dependency centres, although they are mostly intended for occupational therapy.

In fact, on the whole the system of rehabilitation for dependency patients is in its infancy. This applies in particular to drug dependent patients because their rehabilitation requires a long time, resourceful and flexible approaches, specially equipped premises and solutions for the material support of patients enrolled in complete rehabilitation programmes. The theoretical prerequisites for an integral, ramified rehabilitation system have been devised but their practical implementation in the different regions of the country has met with varying degrees of success. At present the Russian Federation has 164 state drug dependency establishments providing rehabilitation support; they include 66 outpatient establishments, 43 clinics, 25 rehabilitation centres and 30 day-clinics. The number of beds for rehabilitation of drug-dependent patients in the establishments of the state drug dependency service stands at 2 121. One particular problem is the rehabilitation of HIV-infected drug-dependent patients; at present 562 such patients are taking part in rehabilitation programmes, accounting for 15.7% of rehabilitation patients.

4.1 Questions relating to the treatment of patients with alcohol or drug addictions

To guarantee the rights of patients in the Russian Federation to receive comprehensive, up-to-date, differentiated and phased treatment, standards for

the diagnosis and treatment of drug-dependent patients have been drawn up. Firstly, applying these standards prevents the needless commercialisation of treatment and the unjustified shortening of treatment programmes. Secondly, they provide for an individual, differentiated approach, in line with the patient's clinical state, the stage their illness has reached and the conditions of treatment. Thirdly, the standards simplify and provide a real basis for budget funding of drug dependency assistance and make it easier to resolve questions of medical insurance.

The section on standards lays down the requirements for treatment and stipulates full and unconditional non-use of alcohol and drugs by the patients. The so-called "controlled" or "socially acceptable" consumption of these substances is in strict contradiction with fundamental clinical and pathogenic principles governing dependency illnesses and therefore ruled out. This is also the case for substitution therapy for drug addicts, which is prohibited by law in the Russian Federation.

Scientific knowledge and clinical practice in the area of drug dependency were closely followed in the development of standards for the diagnosis and treatment of drug-dependent patients. This was also done to provide the required quality levels. The required scientific information is garnered, firstly, through the National Scientific Centre on Drug Dependency, which is responsible for these tasks, co-ordinates all programmed scientific research carried out in the area of drug dependency countrywide and ensures that it has adequate information on the findings. Secondly, the centre director, who is the chief drug dependency specialist of the Russian Ministry of Health Protection and Social Development, runs twice-yearly conferences of the chief drug dependency specialists of all the regions, where the latest scientific developments are reported and information is exchanged on practical experience and various innovations at regional level. Other sources of constructive vocational knowledge are published scientific articles in journals and the publication of drug dependency manuals (the last two-volume manual was published in 2002 and a reprint is currently being prepared).

In addition, psychiatric doctors specialising in drug dependency throughout the country are guided in their work by "methodological recommendations" on various questions of treatment and rehabilitation for patients suffering from alcohol or drug addiction, which are approved, ratified and distributed on a centralised basis by the Ministry of Health Protection and Social Development, via regional drug dependency centres. These recommendations are devised in various scientific and treatment and prevention establishments, generally by their own initiative, which indicates the proactive and productive nature of their work. The recommendations are then appraised by experts and reviewed by the authoritative scientific centres, after which the chief drug dependency specialist's department takes the final decision on whether to publish them or not.

The problem of dual diagnosis is linked chiefly to the need to differentiate between mental impairments forming part of the clinical picture of a drug-related illness (e.g. affective disorder) and similar states with origins in a different disease, which is extremely important when determining the right treatment.

The treatment of patients with alcohol and drug addictions who have committed criminal offences is carried out in accordance with the court sentence. If the crime is not classified as serious, the serving of punishment may be replaced by compulsory treatment in a drug dependency establishment in the area where the person is resident. In other cases patients are treated in the place where they serve their sentence.

Slovak Republic

1 Demography

The Slovak Republic (Slovakia) is a landlocked country located in central Europe. It covers an area of 49 034 square kilometres and has an overall population of 5 389 180 inhabitants with 425 459 inhabitants in its capital Bratislava according to the census conducted in the 2005. Slovaks form the majority of the population (86%), and other minor ethnic groups are Hungarians (10%) and Roma (2%). The official state language is Slovak, but Hungarian is also widely spoken, especially in the south of the country. The majority of Slovak citizens (69%) identify themselves with Roman Catholicism, the second largest group with no particular religion (13%), 7% are Lutherans and 4% are Greek Catholics. Slovakia is a semi-rural country. Life expectancy was 70 for males and 78 for females in 2005. The net migration rate was 3 403 people.

Historically, the territory was for several centuries part of Austria and the Austrian-Hungarian Empire till the year 1918. It constituted the eastern part of former Czechoslovakia from 1918 to the end of 1992. Slovakia has been an independent country after its peaceful separation from the Czech Republic as of 1 January 1993. It is a parliamentary democracy, and has been a member of the European Union since 2004. The currency is the Slovak crown (SKK), and at current exchange rates, 35 SKK will buy you 1 euro. The average monthly salary is 20 000 SKK per employee. The unemployment rate was close to 8% at the end of 2007. The main industries are car and steel-production, the chemical industry and forestry.

2 Epidemiology of drug use

Mostly volatile agents and some sedatives were abused before the fall of the Iron Curtain in the year 1989. They did not cause a serious health problem, however. Significant increases in illicit drug use mostly by youngsters started in the 1990s. Cannabis and heroin have dominated the drug scene in Slovakia. The epicentre was in the capital Bratislava and it spread gradually over the whole of the country. However, the majority of drug users are in the capital. The peak of the heroin epidemic was in the mid-1990s, which, as a consequence, has seen high treatment demand in the time period from 1996 to 2001. Heroin users at that time formed more than 80% of all treated cases, which was 32 treated patients with dependence on opiates per 100 000 of the population. The ratio dropped to 13 per 100 000 in 2005. Remarkable increases in methamphetamine use and treatment demand have occurred at the turn of the 21st century. Despite the fact that we have recorded a

significant decline in intravenous heroin use, this in turn was replaced partially by injecting methamphetamine users. Poly-drug use has also been on the increase for several years. The average age of patients treated for drug dependence oscillates between 20 and 24 years of age.

Slovakia has one of the lowest prevalences of HIV/Aids in the general population in Europe – about 4 per 100 000 of the total population. In addition, the prevalence of HIV among injecting drug users is less then 0.01%, whereas up to 50% of them were infected with the hepatitis C virus in 2005 and 12% were positive for hepatitis B antibodies in the Bratislava sample. This was formed by the patients who contacted the treatment facility for the first time with a request for treatment in 2005. However, the absolute total figures of detected infected drug users entering treatment have been on a continuous decline for some time.

3 Short history of drug treatment

Specialised medical treatment of people with drug dependencies has developed in parallel with drug epidemics. Besides the general psychiatric services, which provide detoxification, eight specialised treatment centres for drug dependents have been established by the Ministry of Health in Slovakia. After a sharp decline in the demand for treatment after the peak of the drug epidemic, two of them were recently closed down. The treatment approach was influenced by the US-Italian project for training drug treatment personnel from central European countries at the beginning of the 1990s. Residential treatment is planned usually lasting for 90 days, including a detoxification period. The outpatient detoxification programmes are also provided in the specialised clinics, with medications, cognitive-behavioural therapy, and individual and group therapy. The first needle-exchange programme was established in 1994 and the first methadone maintenance programme for opiate users in 1997. Non-governmental organisations specialised in street-work, aftercare and social reintegration have developed these services in response to the needs of drug users.

4 Organisation of treatment services

Treatment services in broad definition consist of premedical care, medical care and aftercare.

Premedical care is covered mostly by NGOs with accreditation provided by the Ministry of Social Welfare and Family. Social mediation, counselling and needle-exchange programmes are the main tasks carried out by the NGOs and as such concentrate on harm-reduction activities. The majority of personnel are social work graduates from the universities and student volunteers.

The main bulk of the treatment takes place in the health facilities, which are under the responsibility of the Ministry of Health in Slovakia. Treatment is conducted in general or specialised psychiatric in- and outpatient facilities. Patients enter by referral from general practitioners or as self-referrals. The health facilities are either public, established by the state or the cities, or private for profit and also not for profit, established by NGOs. The staff of specialised treatment facilities consists of medical doctors, specialised in psychiatry, and psychiatric nurses with a specialisation in the medicine of drug dependencies. The highest degree of specialisation is in the centres for treatment of drug dependencies, which admit all patients with dependencies on psychoactive substances, either licit or illicit. Moreover, the maintenance programmes for patients with opiate dependence are located in these settings.

Residential facilities for aftercare have been established by the city or region, and are non-governmental institutions with the exception of two. Their principal task is social reintegration of patients after their treatment in the health facilities. They are also obliged to obtain accreditation from the Ministry of Social Welfare and Family. These institutions can receive finance from the regional governments and cities. Psychologists, social workers, educational therapists and sometimes also ex-users are employed here. Professional supervision is guaranteed by staff members with a university degree in psychology or social work. The majority of the rest of the staff have also completed a course for counsellors with a focus on drug dependency. Specialised treatment is also provided in the prisons.

5 Services

A variety of services are on offer to people with drug-related problems. However, these have not achieved full coverage and, more to the point, is the difficult geographical accessibility of all treatment programmes.

The principal political document is the National Programme on the Fight against Drugs in the Slovak Republic. The current Deputy Prime Minister is responsible for co-ordination of the programme and he chairs the Committee of Ministers for Drug Control and Drug Dependencies. The Minister for Health and the Home Secretary are vice-chairs of the committee. The National Programme on the Fight against Drugs is designed in line with the framework of the European Drugs Strategy and the European Drugs Action Plan. It also reflects the global recommendations of the United Nations General Assembly Special Session (UNGASS) on the World Drug Problem. The tasks of the National Programme on the Fight against Drugs are distributed among participating sectors depending on their role in the supply and demand reduction activities. The Ministry of Health of the Slovak Republic, the Ministry of Social Welfare and Family and the Ministry of Education are the main partners in drug demand reduction activities at national level.

The concrete tasks are further subdivided: the Ministry of Education has principal responsibility for the programmes in the field of primary prevention, the Ministry of Health is responsible for treatment and the Ministry of Social Welfare and Family is responsible for the social reintegration of people with drug dependency. The services for people with drug-related problems are vertically and horizontally interconnected. There is co-operation with the ministries of justice and the interior, through common respect of non-violence, as well as basic human rights and the personal data protection of individuals. This is, in the main, related to the incarceration, as a result of different criminal offences, of people with drug dependence who are in need of treatment. There is an effort to organise the services in such a way that the continuity of care is secured.

With the exception of the involuntary treatment ordered by the courts, the majority of the treatment entries are based on the personal, voluntary decisions of the individuals. Information about treatment options is provided by counsellors, street-workers, on the Web and also during the process of admission into the specific treatment facility by qualified health personnel.

Harm-reduction activities provided by street-workers or specialised treatment centres are an important part of the complex care for drug users in the so-called "stepped care" model. In particular, intravenous drug users can protect themselves by exchanging sterile injecting equipment and can be vaccinated against hepatitis B and A. The above-mentioned programmes are sometimes also the contact points for future treatment entries. Every Slovak citizen has by law full health insurance coverage, so treatment is free of charge.

Detoxification can be realised on an out- or inpatient basis in the specialised health facilities. It is medically assisted. Detoxification treatment varies according to the type of drug dependence developed. Detoxification from dependence on opiates has been the most requested in the past. In the last few years, requests for detoxification from methamphetamine and from cannabis are on the increase. Poly-drug use and dependence is a topic of concern these days. The treatment protocols for detoxification include the use of opiate agonists, such as methadone, buprenorphine, codeine but also other sedatives. The inpatient, residential detoxification programme usually does not exceed fourteen days, however, outpatient detoxification could be much longer. Detoxification is done mostly on a voluntary basis. There is no choice other than drug-free treatment after incarceration, as substitution is not available in the prisons. The option to continue with treatment for dependency on an in- or outpatient basis is offered to patients at the end of detoxification treatment. A physical and mental health status examination is a precondition to detoxification. Free testing for HIV and hepatitis is also offered. There are no waiting lists for detoxification in Slovakia.

The admission to a methadone or buprenorphine (Suboxone) maintenance treatment programme is another option, besides detoxification, for people with dependence on opiates. This is the case in big cities such as Bratislava, Košice and Banská Bystrica. However, methadone maintenance is not available in all parts of the country. The maintenance treatment of opiate dependence is organised in complex programmes, where cognitive-behavioural therapy, personal counselling, group psychotherapy and medical care are part of the programme. There is no limitation to the length of maintenance treatment. The recommended minimum time, according to the Slovakian protocol, is 12 months, which of course, is not achieved by all patients. Ceiling doses of methadone do not exist for daily administration in maintenance treatment. Medication is dispensed in the specialised outpatient clinics under the supervision of health personnel. Random urine analysis is part of the treatment. Cognitive-behavioural therapy is also an important component; for example take-homes are given depending on uncontaminated urine, but this is not the only option. For those who are unable to adhere to the behavioural rules there is also the so-called "harm reduction" branch in the largest methadone maintenance programme in Bratislava, where patients do not have to provide urine samples, but have no take-home medication except for at weekends. If they wish to terminate treatment prematurely, or switch to the in- or outpatient detoxification programme, they are allowed to do so. This option is given to patients with opiate dependence, but they do not constitute the majority of all treatment demands due to drug dependency at the moment. They also have the possibility to choose another option which is the only one available for patients with other drug dependencies: drug-free treatment.

So-called drug-free treatment follows the detoxification period, which is determined by the cessation of withdrawal and negative urine analysis for drugs of dependence. It is understood that "drug-free" treatment of drug dependence in the health institutions is the type of treatment without agonists after detoxification, but not without any other medication. Different psychotropic pharmaceuticals are used during detoxification and for the signs of protracted withdrawal after the detoxification period. Treatment plans are set up for a minimum of 12 months for optimal treatment outcome. The patient has the option to either start with inpatient treatment with 90 days of residential therapy, to continue on an outpatient basis after inpatient detoxification lasting usually for 14 days, or even to start from the beginning with the outpatient programme. The treatment is complex, but with the extended period of abstinence, the psychotherapeutic approach is becoming more and more important. Individual and group therapy and the use of cognitive-behavioural therapy are starting to dominate different programmes which are run on an outpatient basis. The urine analysis is an important part of the system. It is especially important as evidence in

the medical records of those patients who have been ordered to undergo treatment by the courts.

There are different types of programmes mostly run in accordance with the type of drug which led to the patient's dependency. There are special outpatient treatment programmes for opiate users, cannabis users, stimulant users and, of course, alcohol dependency and also for adolescents. There are no special treatment programmes for patients from the minority population groups or for women. Patients who are Roma (Gypsies) and Hungarians did not show any interest in being separated from the patients from the majority population. It is the same case for women in treatment. However, during group therapy, if there are more women in the programme, an extra session from time to time is offered to them to discuss specific sex and gender issues. A special treatment protocol exists for pregnant women with dependency on opiates. If they were on illicit drugs during pregnancy, the maintenance treatment is offered to them as the first option, but if they choose to detoxify themselves, this is medically assisted.

The number of patients with chronic and multiple psychoactive substance use is increasing. The additional problems with alcohol or other substances must be dealt with later on within the treatment period. People with dependencies on alcohol and illicit drugs are treated in the same treatment centres, but in different outpatient programmes and sometimes in separate inpatient wards. An increase in dual diagnosis has been recorded in the health facilities. Besides dependency, psychotic conditions, schizophrenia-like or affective mood disorders are on the increase among patients, particularly in the last five years. Toxic psychosis is frequent after an excessive use of methamphetamine, but also in association with heavy cannabis use. The patients are treated on psychiatric wards during the acute psychotic period, but afterwards they are referred to specialised programmes for treatment of their dependence.

The majority of the patients are young due to the late onset of the illicit drug epidemic in Slovakia. The signs are that the opiate epidemic is in decline and thus there is a shift in the age of the patients in treatment to the older age-groups. The most remarkable changes are those seen among adolescents. Cannabis use is still popular in some parts of the youth sub-cultures, but so-called "hard drugs" are out of fashion now. The first admissions of adolescents due to drug dependence are not as frequent as they were a decade ago, when a special unit for adolescents with drug-related problems was built in the mental hospital close to Bratislava. A special ward for pregnant women with drug dependence was also organised in one large general hospital in the capital city in the mid-1990s. Because of the significant drop in the number of patients, both units have been closed down. The same happened to two of the eight specialised treatment centres for drug dependency in the country.

Special attention is paid to the screening and treatment of hepatitis C infection, which is spreading predominantly among intravenous drug users in Slovakia. Interferon treatment is offered free of charge and organised in cooperation with hepatologists. The medical protocol for interferon treatment has no limitations for patients who are in methadone or buprenorphine maintenance programmes, but reimbursement from the health insurance companies is limited only to those who can provide evidence of at least six months of abstinence within a drug-free programme. Discussion is continuing among all interested parties with the intention of solving this problem.

Within the judicial system, the courts can sentence a drug user to mandatory treatment, but only if he/she committed a crime. Drug use is not criminalised, but possession of any amount of the illicit drug is a criminal offence. Mandatory treatment based on such a court order is specified by the court, and whether this should be undertaken in an inpatient or outpatient clinic. This treatment participation is not voluntary and, if the patient does not comply, he/she can be additionally sentenced by the court. Mandatory treatment of drug dependence can be undertaken in or out of prison. Any inmate, if she/he has a drug dependency can also ask for treatment on a voluntary basis in the prison. There are "drug-free" zones and a specialised ward for dependencies was built in the Slovak prison system recently. It has medically assisted treatment, which is paid for by health insurance. No harm-reduction programmes have been implemented in Slovak prisons. The needle-exchange programmes, or substitution therapies, are not available to prisoners.

Patients who have been abstinent for more than a year are recommended to attend the aftercare programmes for people with a history of dependencies. Two types of programme exist for aftercare and social reintegration: residential and non-residential. Both are under the responsibility of the social and welfare system. The expenditures of the aftercare providers are not covered by health insurance, but are budgeted for in the social part of the state and city councils' budgets and partially from the Protidrogovy fond (Anti-Drug Fund). The so-called clubs for abstainers are organised mostly on a self-help basis and many of them have institutionalised themselves as NGOs. They are either close to the health facilities or completely separate from them with some degree of professional assistance. The residential social reintegration care is more structured and is mostly provided by NGOs. The programmes are based on a therapeutic community regimen with different models. While non-residential types of aftercare provide psychological support for abstainers and networking with new friends during weekly meetings, the residential programmes set up goals for the full social reintegration of their clients: vocational training, study, safe workplace, and safe alcohol- and drug-free housing. The duration of stay in these residential programmes is from one to two years and sometimes it could be even longer. The majority

of them accept clients of either sex; some admit only male clients while some care for minors who have just finished compulsory primary school.

6 Special issues

6.1 Research and education

The Institute for Drug Dependencies, which has been established at the Centre for Treatment of Drug Dependencies in Bratislava, conducts research in the drug field, as well as a number of universities. The main sources of scientific and up-to-date professional information are published in specialised professional periodicals: *Alkohol a drogove zavislosti* (scientific journal on *Alcohol and Drug Dependence*) and *Cisty den* (the *Clean Day* journal). New information is also accessible at regular yearly conferences on dependency.

A hundred hours of theoretical and practical work forms part of the curriculum of the Course for Counsellors in Drug Dependencies, which has been organised by the Institute on Drug Dependencies for the last 10 years. The participants consist of professionals from different backgrounds working in the field of drug demand reduction. The institute was a partner in the past and is now a co-ordinator of the current DG SANCO international European Union project on the Improvement of Access to Treatment for People with Alcohol- and Drug-related Problems (IATPAD).

7 Strengths and weaknesses

The well-designed, free of charge treatment system with no waiting lists for people with dependence on illicit psychoactive substances is an advantage in Slovakia. Its interconnection with the other health and social services is also very important. All this has resulted to date in very low HIV and hepatitis B seroprevalence among drug users. What is also favourable is the trend towards a decrease in treatment demand related to illicit psychoactive drugs, especially the opiates, which may be the result of a decline in intravenous drug use in the country.

We are also aware of the existing weaknesses in this field in the country. Access of people with drug dependence to treatment for hepatitis C is one of the problems which we are encountering in Slovakia, at present. It is not possible to obtain methadone maintenance or detoxification in the prisons and a specialised ward for adolescents with drug dependence is also absent. Antagonist medication such as naltrexone is not available because it is not registered in Slovakia. These are a few of the issues which should be addressed in the near future. However, the most prominent and worsening problem is the “brain drain” of experienced professionals from the field of drug addiction treatment in Slovakia. In contrast to the situation in the mid-1990s, there are very few new adepts showing any interest in working with

dependent people and many experienced personnel are leaving either for better paid positions abroad or to work in other sectors within the country.

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Slovenia

1 History of drug treatment in Slovenia

The availability of treatment programmes for illicit drug users in Slovenia has been documented since the 1960s. Historically, drug treatment oriented towards abstinence only has prevailed in Slovenia for decades, as elsewhere in the world at that time, and involved detoxification and the application of psychosocial and educational techniques to achieve long-term abstinence. Only a few drug users were seeking this kind of treatment which was predominantly offered by the psychiatric hospitals with operational characteristics that were not directed to addicts' needs.

Until the 1990s it was believed that illegal drug use was not a considerable problem in the country. Thus before the early 1990s not much effort was invested in drug epidemiology/research. The response to drug use was not predominantly based on existing statistics and the rare research findings. It was mainly the product of wishful thinking and the initiative of some individuals and groups with recommendations from knowledgeable experts. The topic of illicit drugs has elicited rather strong emotions among the public. Even among professionals the discussions were often highly emotional and based on ideologies rather than facts. Decisions were based on relatively poor data, as the scientific facts were available only to a limited extent.

Drug injection use was rather rare in Slovenia before the late 1980s. Milčinski and Nolimal, along with their co-workers, studied the extent of treatment demands related to this phenomenon at the beginning of the 1980s and discovered that it was not large (Nolimal and Milčinski, 1985). Altogether 212 drug addicts, injectors and non-injectors, were treated in the psychiatric outpatient centre in the period 1970-1974. According to the first available national report on drug trends from 1982-1984 there were fewer than 100 drug users treated each year in Slovenian psychiatric hospitals (Nolimal and Milčinski, 1985). Of course, that does not necessarily mean that there were negligible health problems with illicit drugs in the country. The treatment demands remained quite small with fewer than 100 drug users seeking treatment each year till 1991. However, in the late 1980s the incidence and prevalence of heroin injection use have increased. The number of drug users seeking treatment has increased in 1991 when two specialised substitute prescribing services in Koper and Ljubljana were established (Nolimal, Krek and Aubrey, 1994). Just a few years later, in 1995, when methadone treatment was formally introduced throughout the country, this number had multiplied to 530 patients receiving methadone substitution treatment.

At the outset of the new wave of drug use in the 1990s, the users had an important impact on the development of treatment programmes, research and policy in Slovenia. Being denied access to methadone treatment (a pilot programme run by a psychiatrist was closed) the users launched a campaign as early as 1990, mobilising the general public, as well as some professionals, to protect their rights. As well as this they linked up with an international harm-reduction organisation and WHO and initiated the first needle-exchange programme in 1991, thus preparing the ground for a relatively progressive drug policy that established a good network of methadone clinics and low-threshold activities.

The users' movement in Slovenia was very strong in the early 1990s but withered somewhat in the following years. However, the users were always involved in decision making and the discussion of important issues, including the development of methadone substitution therapy, and they still run some services (shelters, outreach).

Complete abstinence from the primary substance was the main criterion of successful treatment. Other indicators of treatment effectiveness, such as the improvement of mental and physical health, improvement of social status and quality of life, were not considered to the large extent.

It should be mentioned, however, that the non-governmental sector in the early 1990s developed very specific programmes as a supplement to the public sector, covering various forms of drug treatment. Therapeutic communities and communes such as Project Man, Caritas, Dianova (formerly Le Patriarche), played an important role in developing an integral and balanced drug policy.

2 Influence of research data on development of treatment

Some researchers in Slovenia claim that treatment research data from other countries and international organisations, presumably also relevant for Slovenia, had sometimes been used to identify priorities and to develop new strategies and interventions that had proved effective in those countries. With the recognition of the seriousness of the threat of HIV/Aids in the drug injecting population, the new challenge for drug treatment services was to broaden the focus beyond abstinence to include strategies for reducing the health risks and minimising the harmful consequences of drug use. The methadone substitution programme was clearly one of the approaches to be considered in this situation (Nolimal, 1991). However, the absence of research data and knowledge, including guidelines, manuals and protocols, contributed to existing misunderstandings about the goals and practice of methadone substitution treatment.

There were many misconceptions about methadone. Additional opposition to accepting substitution treatment as an option for drug treatment was inherent in the public opinion response to illicit drug users. Traditionally, the media created a stereotype of a drug user as a criminal and moral deviant. Stigmatisation of drug users and negative attitudes towards this population were prevalent and it was difficult to secure empathy and public support for the provision of these individuals with methadone. Even in treatment centres where a substitution programme was available, the prescribing doctors were stigmatised by their non-prescribing colleagues and this mode of treatment was not fully accepted. Finally, some experts were also concerned that there might be legal obstacles to the substitution treatment and that the prescribing doctors might be violating rules. Even some recovering and abstinent drug users were engaged in active advocacy for drug-free programmes in opposition to substitution treatment. All these contributed to the unwillingness of health professionals to engage in substitution treatment. When the information on the heroin injection epidemic and the HIV/Aids threat was provided through the reports of international organisations such as WHO and the general media, people became aware of the importance of the problem. It was appropriate to proceed with studies of the heroin injecting epidemic as it affected doctors through the sudden increase in treatment demands in most health services all over the country.

The beginning of drug treatment research in Slovenia is connected to epidemiological monitoring by the Institute of Public Health (Nolimal and Milcinski, 1985; Nolimal and Premik, 1992). Later the research was also linked to drug users' involvement. As a group they wanted to legitimise their claims through data collected to prove the necessity of the new treatment programmes. This kind of research was performed with users participating in the research team, as well as in data collection and analysis (Flaker et al., 1993; Nolimal, 1993). This tradition has remained up to this day, as users participate in the research as consultants, interviewers and members of boards.

When the information spread about HIV being a greater danger to the individual and public health than drug misuse, this brought about a fundamental re-examination of the existing responses to drug use and the needs of drug users. Urgent public health concerns about HIV/Aids also motivated the Institute of Public Health to initiate an investigation into the risk behaviours among drug users and prescribing methadone, the latter being the new "semi-legal" response to these problems in the country. Simultaneously, the institute started collaborating with policy makers, professional colleagues and the media to gain their confidence and support. Involving drug users (members of the self-help group Stigma) in the risk reduction advocacy, beyond just recruiting them as research participants, promoted trust in this population and provided other benefits as well. In planning and conducting drug treatment demand studies input from both

drug users and the prescribing doctors was obtained. The advantages and disadvantages of prescribing methadone were weighed according to the nature of the preliminary treatment demand data.

3 Development of national legislation on drug treatment in Slovenia

All the above has led national authorities to develop and introduce modern, coherent and comprehensive drug regulations in Slovenia. Two laws were adopted by the National Assembly at the end of the last decade: the Law on the Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs (1999) and the Law on the Production of and Trade in Illicit Drugs (1999). Whereas the latter sets out the conditions under which the production, possession and trade in illicit drugs are permitted, the first establishes the legal conditions for drug demand reduction activities. Among others the law foresees measures that cover information, medical, educational and consulting activities, medical treatment, social security services and programmes for resolving social problems related to drug use and for monitoring the consumption of illegal drugs.

According to that law, treatment of consumers of illicit drugs shall be carried out in the form of hospital and outpatient clinic treatment programmes approved by the Health Council. Furthermore, treatment shall also be maintained with methadone and with other substitutes approved by the Health Council.

For the implementation of outpatient clinic activity for the prevention and treatment of addiction, centres for the prevention and treatment of addiction to illicit drugs were organised at the primary level as part of the public health service network.

The law also addresses the need for the involvement of non-governmental organisations and the co-ordination of their activities with the national programme.

Based on the legislation, a National Drug Programme was adopted in 2004. It covers the period until the end of 2009. The document was an important milestone in the development of general drug policy and practice in the country. The whole process of drafting and implementing the document linked up a wide variety of actors in the drug field. The national programme was the result of social development and an indicator of harmonisation of the various sectoral approaches in relation to aims, priority tasks, sources and costs. It has also taken into account the international legal framework, UN conventions, the recommendations of the Council of Europe and the European Union and other international organisations in various professional fields.

4 Current situation

In Slovenia at the national level, drug-related treatment is regularly provided by different health, social and civil society organisations (NGOs). The main financial source of funding drug-related treatment in the health sphere is the health insurance system of Slovenia. The public sector is the main actor involved in the delivery of drug-related treatment, mainly medically assisted treatment, but some drug-related treatment is also delivered by NGOs, which are supported by public funding. Drug-related treatment is available within the framework of the public health national service network. Treatment takes place primarily at one of 18 centres for the prevention and treatment of drug addiction (CPTDAs), which are run as a franchise or as a public health service.

To provide treatment at hospitals and special clinics, the government has established a public health institute – the Centre for Treatment of Drug Addiction – at the Ljubljana Psychiatric Hospital. Hospital treatment includes hospital detoxification, psychosocial therapeutic treatment, prolonged treatment and health rehabilitation. Hospital and clinical programmes of treatment, and maintenance with methadone and other substitution medication, are under the supervision of the Health Council at the Ministry of Health.

The Commission for Controlling the Work of the CPTDAs, appointed by the Minister for Health, oversees the treatment centres. This commission checks, among other things, the documentation, human resources and equipment of the centres, the scope of work performed, their methadone maintenance programmes and consultation-based treatment.

The treatment system in Slovenia can be classified into four categories:

1. outpatient treatment;
2. inpatient treatment;
3. detoxification; and
4. substitution maintenance treatment.

Outpatient treatment involves the majority of treated drug users, and the most frequent treatment is substitution treatment (mostly with methadone). It also includes psychosocial interventions, medically assisted treatment, individual or group counselling and a socio- or psychotherapy component. Inpatient drug treatment consists mainly of psychosocial interventions, yet may also be pharmacologically assisted in terms of withdrawal treatment.

Detoxification treatment may take place in inpatient or outpatient settings. Inpatient treatment opportunities include detoxification and treatment lasting 6-14 weeks with the possibility of day care before and after inpatient treatment for up to six months or more. Since 2005, outpatient detoxification

may also be carried out with buprenorphine and slow-release morphine. Substitution treatment with methadone, which was introduced in 1990, is provided either by the doctors employed in these outpatient clinics or by general practitioners, who practice at the CPTDAs. More than one third of the estimated number of problem drug users is in substitution treatment. Buprenorphine was registered in 2004 and in 2005 slow-release morphine also became available. Substitution treatment can only be initiated in treatment centres or prisons.

In 2007, more than half of known drug users in prison were included in substitution treatment as well. Drug-free units together with harm-reduction programmes were developed in recent years. Strong co-operation between treatment services in prisons and treatment centres in communities have been established.

5 Discussion

Many researchers, practitioners, policy makers and politicians in Slovenia identify treatment as being effective in tackling problem drug use and, therefore, attribute great importance to a diversification of the available treatment options. Drug specific counselling, care and treatment services are provided by specialised centres (CPTDAs) within a nationwide network. These services, primarily in the outpatient sector (primary, general health care system), include mainly substitution treatment, but also drug-free treatment. In the past decade the inpatient drug-related treatment sector saw a development from shorter to long-term treatment and more flexibility with regard to possible kinds of (also medical) therapy. This also means that a variety of substitution treatment substances may be prescribed. In quantitative terms, substitution treatment (oral methadone maintenance) has become (in the last 15 years) the most important form of therapy in Slovenia for opiate users.

In 2007 in Slovenia, the substitution treatment possibilities of heroin addiction increased with the new substance which is a combination of buprenorphine and naloxone. An evaluation of the substitution treatment programme was implemented in 2007 by the Ministry of Health. The project was set up as a “twinning light” project in co-operation with the Dutch Ministry of Health, Welfare and Sport, the Trimbos Institute from the Netherlands and the Faculty of Social Work at the University of Ljubljana (Slovenia). The evaluation results show that the substitution treatment programme in Slovenia is well organised and accessible to most drug addicts in comparison with other EU member states. The evaluation report made some recommendations for improvement, namely, an improvement in the psychosocial treatment of patients, and in interdisciplinary and intersectoral co-operation in the field of drug demand reduction, and better co-operation with other programmes in the field of drug demand reduction.

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West of Europe

Belgium

1 Demography

The population of Belgium is 10 396 421 (2003). Its capital is Brussels and the languages spoken in Belgium are Dutch, French and German. Belgium has a domestic product of €283 700 million (2004), with an annual growth rate of 2.7% (2004). The country covers an area of 30 528 square kilometres, giving a population density of 339 persons per square kilometre (2003).

Belgium is a small country with an advantageous location in north-western Europe. Its territory is bounded to the north by the Netherlands, to the east by the Federal Republic of Germany and the Grand Duchy of Luxembourg, and to the south by France.

Belgium has undergone major changes over the last few decades in line with the aspirations and specificities of its inhabitants. Originally a unitary state, it has evolved towards a federal model. In 1993 it became a federal state comprising several communities and regions (see Appendix 1).

The country has three different communities. The Flemish community in the north speaks Dutch and is the largest one. The Walloons come second, living in the south and speaking French. Brussels is a bilingual region (although most of its inhabitants are French-speaking). Lastly, a small German-speaking community lives in the far eastern part of the country.

Belgium has three regions, namely: the Flemish Region, the Brussels-Capital Region and the Walloon Region.

The country has a solidarity-based society. Family allowances, pensions, sickness insurance, unemployment benefit and paid leave are guaranteed for those entitled to them. The health care provided is among the best in the world. Where the standard of living is concerned, despite the disparities among the regions, Belgium also ranks among the top countries worldwide.

2 Epidemiology of drug use

Cannabis is the commonest illegal drug in Belgium. Of the population aged 15-64, 13% have consumed cannabis at some stage in their lives (Bayingana et al., 2006, p. 497).

In Belgium, cannabis is mainly used by people in the younger age brackets. One in four Belgians between the ages of 25 and 34 has consumed a cannabis derivative (hashish or marijuana) at least once (ibid., p. 497). Most users reportedly try an illegal drug for the first time at around the age of 14 or 15 (Sleiman and Roelands, 2006, p. 27).

There are no recent studies of the prevalence of other illegal substances (ibid., p. 52). Data will be available on this subject in 2009, as Belgium conducts a national health survey every four years. The prevalence of illegal drugs will be addressed in the next national health survey (to be conducted in 2008).

From 1998 to 2004, drug mortality in the Brussels-Capital Region exceeded that of the Flemish Region (26 and 6.9 cases per million inhabitants, respectively) (Jossels et al., 2007, p. 8).

Most drug-related deaths (82.2% are men, usually between the ages of 20 and 39 (ibid., p. 8). In 45% of all cases death is caused by multiple drug-taking. Opiods cause 39.4% of the deaths (ibid., p. 9). In the regions observed, mortality remained stable over the 1998-2004 period (ibid., p. 12).

Among HIV-positive individuals, the proportion of drug users resorting to intravenous injection has fallen (decreasing from 10% in 1986 to approximately 3% in 2004) (Sleiman and Roelands, 2006, p. 71).

A 2004 survey of the whole population revealed a hepatitis C prevalence of 0.11% (quoted in Plasschaert et al., 2005, p. 2). Much higher percentages are observed among the drug-using population, where the overall prevalence of hepatitis C is 30% (ibid., p. 25).

Hepatitis B prevalence in the drug-using population is 11% (ibid., p. 28). HIV prevalence is 2% (ibid., p. 32).

3 Short history of drug treatment

The political configuration of Belgium is rather peculiar. Five reforms were carried out to transform the Belgian state into a federal state, namely in 1970, 1980, 1988-89, 1993 and 2001.

The first reforms in 1970 established the three communities corresponding to the country's three language communities, that is, the Flemish Community, the French Community and the German-speaking Community.

The idea of creating regions originated in a desire for more economic independence. Three regions emerged, namely, the Flemish Region, the Brussels-Capital Region and the Walloon Region.

Like other countries, Belgium has been running a full system of treatment for drug users[6] for many years now.

There has been an increasing trend recently for drug users to have access to the health care system. Drug addiction is now classified as a disease. Drug users (and therefore their treatment) have been destigmatised. Consequently,

6. "Treatment for drug users" refers to treatment of both addictions and other aspects of the drug-use issue.

drug users can be treated anywhere in Belgium. There are specialist centres, but drug users are free to seek treatment wherever they wish.

A further feature of the Belgian health care system is that it endeavours to "customise" patients' treatment. In addition to the traditional structures, there is a wide range of projects geared to meeting the specific needs of drug users and adapting to changing types of drug addiction.

In 2001 the federal government produced its Federal Policy Memorandum on Drugs. It was (and is) geared to providing a framework for the priorities in the drugs policies implemented by the various authorities in the country (Sleiman and Roelands, 2006, p. 15).

Lastly, one of the major developments in recent years (since January 2005) has been the change in the status of cannabis. A distinction is now drawn between cannabis and other illegal substances. Possession by a person over the age of 18 of a given amount of cannabis for personal use remains punishable but is no longer prioritised by the public prosecutor's offices (under a new tolerance policy). It is worth noting that cannabis smoking by a minor is still prohibited (ibid., p. 15).

4 Organisation of treatment services

Powers and responsibilities in the health field are considered "customisable" by the communities, which are theoretically responsible for such care. Article 5(1)I of the Special Law of 8 August 1980 provides that "health policy" is a "customisable field"; the policy on administration of treatment inside and outside health care institutions, health education and preventive health care are all matters for the communities. Where such theoretical jurisdiction is concerned, the same article sets out a number of exceptions for which the federal government is responsible.

The federal state is responsible for health care insurance. The Ministry of Social Affairs and Public Health is accordingly responsible not only for regulations on but also for the enforcement and practical implementation of legislation on health care insurance.

The state is also responsible for defining the basic rules for and the main lines of inpatient treatment (e.g. in hospitals) and outpatient care (e.g. the integrated home care services).

It should be noted that the federal government also takes responsibility for a number of aspects of the in- and outpatient services, including guaranteeing medication and organising the health professions, general practitioner surgeries and provision of home nursing care.

In addition to the aforementioned responsibilities vis-à-vis health care provision,[7] the federal state also has a number of limited powers in the field of health education and prevention. The Special Law stipulates that the federal level is exceptionally responsible for compulsory vaccinations. Furthermore, the federal government conducts national preventive measures in certain cases (e.g. responsibilities in the field of tobacco advertisements).

In the health policy field, the communities have responsibilities in administering in- and outpatient care as well as in the field of health education and preventive health care, in areas for which the federal level lacks jurisdiction. This implies that the communities are responsible for laying down rules for institutions that fall under their jurisdiction (e.g. mental health centres), for implementing federal regulations, with the requisite adaptations, inspecting federal institutions and issuing regulations to complement the federal ones. The second area of responsibility involves launching general campaigns, organising special awareness campaigns and conducting specific types of inspections.

Apportioning responsibilities in the health field, and therefore in the drugs field, necessitates a consultative body. The Cellule Politique de Santé Drogue (CPSD – Health Policy Unit on Drugs) was set up in May 2001 to devise a drug policy from a comprehensive, integrated angle. The CPSD, which is chaired by Professor I. Pelc who represents the Federal Health Ministry, comprises representatives of the ministerial cabinets responsible for health in both the federal state and the federate entities (Flemish Community, French Community, German-speaking Community, Walloon Region, Brussels-Capital Region, COCOF (Commission Communautaire Française – French-speaking institution of the Brussels-Capital Region) and COCOM (Commission Communautaire Commune – joint institution for both language communities in the Brussels-Capital Region)).

Lastly, a General Drugs Unit is shortly to be set up, operating on the same basis as the CPSD but with responsibility for all political fields relevant to the drugs issue (health, justice, interior, etc.).

5 Services

5.1 Detoxification

Belgium implements two detoxification techniques: conventional detoxification and ultra-rapid opiate detoxification (UROD).

7. "Provision" here refers to both medical and non-medical provision (social welfare provision, etc.).

5.1.1 Conventional detoxification (the usual approach)

Conventional detoxification may be provided throughout the health care network and also in the very many specialist in- and outpatient services available nationwide. The drug withdrawal system covers a variety of substances (opiates, cocaine, cannabis and methadone). The addictive substance is either removed immediately or reduced gradually. A specific psycho-medico-social programme is implemented to treat withdrawal symptoms.

It should be noted that the more difficult detoxification cases are transferred to specialist centres and university hospitals, which have the requisite specialist resources.

5.1.2 UROD (ultra-rapid opiate detoxification)

This detoxification method is used for specific types of cases involving opiate addicts requesting rapid detoxification (taking only a few days). Given the special characteristics of this withdrawal method, it is only provided by a limited number of specialist hospitals. Like other withdrawal techniques, UROD requires a special psycho-medico-social programme.

5.2 Assessment/organisation of provision

Depending on their specific powers and responsibilities (see section 4 above), individual authorities prioritise their activities in accordance with national and international recommendations. Each authority aims to establish a programme in line with a long-term action plan. The programmes set out the priorities in terms of target groups, strategies, players and problems.

5.3 Treatment

5.3.1 Substitution treatment

Any Belgian physician may prescribe substitution treatment, regardless of where the consultation takes place (private surgery, centre specialising in substitution treatment, hospital, etc.). However, all medical staff involved must comply with rules of good practice.

The Belgian model therefore comprises a variety of modes of provision. Importantly, no negative feedback has ever been received on this approach (Ledoux et al., 2005, p. 268).

The most frequently used refundable medicines are methadone (prescription preparation) and buprenorphine (in Subutex® form). A series of safety measures (relating to the composition, issue and packaging of the medication) are taken to guarantee the safety of patients and their entourage (e.g. adding a gelling agent to prescription preparations in order to prevent intravenous injection). The number of patients undergoing substitution treatment is estimated at between 9 250 and 10 000.

Substitution treatment in Belgium is based on a number of legal texts, particularly the Royal Decree of 6 October 2006 on substitution treatment. This text is designed to optimise provision for patients undergoing substitution treatment.

This royal decree requires physicians who prescribe substitution treatment for more than two patients to have undergone specific training in substitute-supported treatment for drug users or to possess adequate expert knowledge. The physician must also join a professional network providing mutual knowledge enhancement.

The Royal Decree also provides for the nationwide registration of substitution treatments. Such registration is geared to gathering and analysing data on and monitoring all current substitution treatments.

5.3.2 Drug-free treatment

The federal government has been funding most of the institutions specialising in the drug-use field since 1980. Five categories of institution are funded (De Ruyver et al., 2004, p. 19):

– therapeutic communities;
– crisis intervention centres;
– day centres;
– "*centres de session*" (mental health centres);
– *maisons d'accueil socio-sanitaire* – MASS (socio-health reception centres, specialising in provision for patients undergoing substitution treatment).

Treatment is often supported by a medico-socio-psychiatric reference framework and personalised support, and is generally provided in several phases:

– detoxification, observation and diagnosis;
– assessment of motivation to continue with treatment;
– multidisciplinary provision programme;
– social rehabilitation;
– post-treatment monitoring and relapse prevention.

Most of the other authorities in the country (the Flemish Community, the French Community, the Walloon Region and the COCOF) also finance health care structures in accordance with their powers and responsibilities (e.g. needle-exchange services funded by the communities).

Lastly, to complete the picture, some towns and provinces also fund a small number of health care structures (ibid., p. 97).

5.3.3 Dual diagnosis patients

Over the past few years clinicians have noted increasing numbers of patients subject to dual diagnoses (that is, drug-taking problems accompanied by a mental disorder). Such patients are particularly vulnerable and currently lack any form of provision.

A pilot project was therefore launched in 2002, setting up two units (one in Flanders and one in Wallonia). These units provide intensive and integrated treatment (17 full-time staff equivalents catering for 10 beds) for both problems (drug-taking and mental disorder). After a period of intensive treatment (six months, possibly extended by a further six months), the aim is to stabilise patients and refer them to other services to continue with the treatment. The pilot project is currently being assessed in order to ascertain whether it can be established nationwide.

Finally, two institutions (subsidised by the National Institute of Sickness/Disability Insurance – INAMI) are currently developing a similar type of treatment programme.

5.3.4 In- and outpatient treatment

For inpatient treatment, see Section 5.3.6 below. The day centres, *centres de session* (mental health centres) and MASS provide outpatient treatment.

The type of treatment provided by these institutions can be illustrated by a description of that provided in the mental health centres.

The degree of specialisation in the support and treatment provided for problem drug users varies extensively. Some mental health centres work exclusively on providing outpatient care for problems linked to alcohol, medicine, illegal drugs and/or gambling. Few of the mental health centres are specialised and most deal with all types of problems.

This situation has been changing for some years now. The sector has seen a number of mergers, and most of the merged mental health centres now have specialist teams to deal with clients facing drug abuse problems.

Therapeutic provision is diversified. Individual, relational, family and group therapies are provided. The therapeutic objective in all mental health centres is partial or total rehabilitation of mental health, with due regard to the drug abuse problem. The ultimate aim of the support measures is total abstinence, or at least a decrease in the use of one of the psychotropic substances.

5.3.5 Drugs and/or alcohol and prescribed drugs

The federal state has opted for a system mandating the front-line actors (general practitioners) to treat people who are exclusively addicted to benzodiazepines.

General practitioners are accordingly being provided with interactive training courses, which are dispensed by a general practitioner and a psychologist (and more recently a pharmacist), with participants working in small groups. The courses are geared to developing skills in providing support for patients with medication problems or requiring withdrawal of sleeping tablets and/or sedatives.

Another aim of such training is to help general practitioners provide general treatment for anxiety, stress and sleeping disorders and manage their prescription of benzodiazepines and other alternative non-drug treatments (relaxation, cognitive-behavioural techniques, etc.).

In addition to such training for general practitioners, similar courses are also organised for pharmacists, so that they can provide fuller information for patients inquiring about taking or stopping sleeping tablets and sedatives.

5.3.6 Availability/link to somatic and psychiatric treatment

Where public health responsibilities are concerned, people with disorders linked to consumption of psychoactive substances are provided for by "traditional" health care institutions such as general hospitals (psychiatric departments), psychiatric hospitals, psychiatric health centres and sheltered housing projects. There are 78 hospitals in the Flemish Region, 39 in the Walloon Region and 17 in the Brussels-Capital Region.

Psychiatric hospitals and the psychiatric departments of general hospitals are the hospital services most frequently involved in assisting drug users (ibid., p. 88). In Wallonia and Brussels, three hospitals have developed special programmes to treat drug users. In Flanders, 13 hospitals have developed special programmes for drug users.

The federal authority responsible for public health is also funding a number of pilot studies on the development of crisis units for individuals with disorders linked to drug use, including a post of case manager, and units for dual diagnosis patients (see Section 5.3.3 above) (CPSD, 2008, p. 9).

5.3.7 Rehabilitation services linked to treatment

The various specialist structures in Belgium comprise all the usual rehabilitation services.

An addiction fund was set up in 2007 to finance innovative projects (young people, pregnant women, etc.) as part of the treatment programmes for drug users. It helps meet the specific needs of the sector.

One project, for instance, is geared to placing young drug addicts (aged between 18 and 25) in sheltered housing. The main aim of this project is not to ensure that the young people stop taking drugs immediately, but rather to help them learn to adopt a responsible attitude to drugs. The young

people are encouraged to adopt a controlled mode of consumption of drugs, as well as to consult outpatient services with an eye to socio-occupational rehabilitation.

5.3.8 Treatment for young people

Generally speaking, Belgium has three types of treatment centre:

– centres for adults only (the most frequent case);

– centres open to both adults and teenagers;

– centres exclusively catering for teenagers.

Belgium has a small number of residential services dealing specifically with young drug abusers (slightly more in Flanders than in Wallonia). Inpatient provision for teenagers requiring this type of treatment is difficult, given the shortage of places.

On the other hand, outpatient services are more readily available (e.g. outpatient day centres). Some of these centres provide treatment for young people, as well as support groups for teenagers and/or their parents.

Noteworthy schemes (non-exhaustive list)

International Cannabis Need of Treatment (INCAN) research project (3)

This research project is primarily geared to the effective implementation and evaluation of a treatment method (multidimensional family therapy – MDFT) developed in the US for a group of young people with cannabis problems. It will conduct a scientific comparison (in a European context) of the effects of MDFT treatment with those of other traditional types of treatment.

Resource development projects

Several projects are geared to helping drug-using parents to restore their relationships with their children and develop their educational potential. One of the projects specifically targets parents from cultural and ethnic minorities.

Another project is designed to prevent young people from relapsing and to reinforce the results of the treatment after its completion.

Lastly, another project is aimed at the parents of young drug abusers. It comprises individual interviews, training evenings, mutual support groups and information from the Internet and other media.

5.4 Gender issues

5.4.1 Pregnant women/families with very young children

A number of such programmes are operating in Belgium. Drug-using mothers attending residential rehabilitation programmes in one establishment are accommodated with their children in a separate section. This not only gives drug-using mothers access to residential therapies but also prevents them from being separated from their children for the purposes of their treatment (CPSD, 2008, p. 14).

Noteworthy schemes (non-exhaustive list)

Several projects are being run for children (aged between 8 and 12) of drug-using parents. They are generally intended to provide the children with psychological education. The objectives are to inform children about the consumption of psychotropic substances and the consequences, develop their social skills and problem-solving abilities and reduce their social isolation.

Another project is geared to providing outpatient care for young people with slight mental deficiencies or limited intellectual capacities. Experience has shown that traditional types of treatment are often unsuited to the needs of this particular target group. This is why the project has developed a therapeutic methodology suited to this group.

5.5 Treatment within the criminal system

This matter is governed by Ministerial Circular No. 1785 of 18 July 2006, which incorporates sections of the General Principles Law on Prison Administration and the Legal Status of Prisoners. The principles enumerated include those of the equivalence and continuity of treatment in the outside world.

The ministerial circular stresses the need to prevent addiction in prisons, to collect information on previous medical history, to reduce drug-use risks and to provide treatment for people consuming narcotic substances.

In connection with opiate addicts, the ministerial circular provides (for the purposes of treatment continuity and equivalence) for:

– continuing with a substitution treatment (with methadone or buprenorphine) commenced before imprisonment; and/or
– initiating a new substitution treatment for prisoners so requesting.

Specific conditions are attached to these two facilities (as set out in a specific technical protocol on substitution treatment) in order to prevent accidents linked to prescription of inappropriate treatment endangering the

prisoner's life or possibly fuelling a parallel market (e.g. checking with the prescribing doctor on the previous treatment, ascertaining opiate addictions and tolerance of the substitute used, verifying compliance with the treatment, signature of a treatment contract, etc.).

The aims of this type of substitution treatment are either:

– complete withdrawal of the drug, or
– maintenance of the substitution treatment for the duration of the prison sentence.

Furthermore, the ministerial circular stresses the need to provide psychosocial therapy for drug-addicted prisoners. To that end it encourages the use of general or specialist services to assist drug-using prisoners both during and after their prison sentences, in order to prepare for their release (a time when overdoses are common), ensuring that outside operators can take over.

In addition to all these facilities, Belgian prisons can also mandate their local drug assistance groups to make proper arrangements for meeting the needs of the prison population in the field of drug use (e.g. staff training, introducing a "no drugs" section, etc.).

6 Special issues

The consumption of psychoactive substances is primarily considered to be a public health problem. Prevention is the main strand of the strategy, followed by treatment and risk and damage reduction. However, recent studies have shown that Belgium is spending less on preventing illegal psychoactive substances than on other fields, and also less than other European countries (De Ruyver et al., 2004, p. 310).

Moreover, the arrangements for funding prevention apparently differ in the three regions, and joint financing by different authorities is commonplace. More longer-term legal and financial guarantees should therefore be sought for essential activities in the field of prevention, assistance, risk reduction and damage containment.

Treatment should be reorganised, based on ensuring that treatment supply is oriented towards the patients and their health care needs rather than the amenities available (Demotte, 2005, p. 18). This should lead to new therapeutic projects. Consultation on individual patients ought to broaden the consultation perspective with an eye to a consistent policy on the organisation and/or co-ordination of care networks. It would be a case of establishing transverse consultation among therapeutic projects within one target group in order to obtain a structural proposal for treatment channels and networks (Demotte, 2005, p. 16).

A number of national and international statistics point to obvious inequalities in the health field. This is particularly true for the problem of drug-taking. On average, socially vulnerable groups have higher levels of (ab)use of psychoactive substances, as well as greater incidence of co-morbidity. Any integrated policy ought to take account of this point. An effective policy needs comparable epidemiological data to highlight long-term evolutions.

The CPSD must operate without encroaching on the powers and responsibilities of other bodies. It currently lacks the legal expertise and decision-making powers to put forward any clear, proactive proposals. However, it does have a great deal of potential for continuing to orient political initiatives.

Developing an integrated health policy in the drugs field requires providing more and more feedback to other areas of jurisdiction. This raises the urgent need for a new General Drugs Unit.

Lastly, as mentioned above, Belgium enjoys a very central geographical position, but this makes it vulnerable to drug-trafficking. Action to minimise the effects of such trafficking must be stepped up.

7 Strengths and weaknesses

7.1 Strengths

The Belgian health care system is highly varied, elaborate and complex. A wide range of responses are provided to the problems of drug addiction.

As we have seen, Belgium is a country with a fairly wide variety of cultures. Drug-taking habits, the types of treatment provided, and so forth, vary considerably from one community to the other. Logically, therefore, the needs also sometimes vary.

The treatment made available in Belgium provides an adequate response to the needs of most individuals with drug problems. The diverse authorities responsible for drugs policy facilitates an approach that is more closely tailored to specific local conditions and enables pilot projects and new experiments to be initiated (ibid., p. 432).

7.2 Weaknesses

Unfortunately, the system's strength is also its weakness. The responsibilities of the various bodies involved are not always clearly delimited. This applies in particularly to the diversified range of preventive measures, for example drug prevention, peer support and early detection (CPSD, 2008, p. 69). The same holds in the field of assistance and treatment. Political responsibilities in this area are widely differentiated (ibid., p. 432).

The whole situation exposes a pressing need for co-ordination of the activities conducted, but this will also involve more use of limited public resources.

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Information on management and co-ordination of health care insurance in Belgium – www.inami.fgov.be

VAD (for information on action in the Flemish Community) – www.vad.be

Concertation Toxicomanies Bruxelles (for information on action in the Brussels-Capital Region) – www.ctb-odb.be

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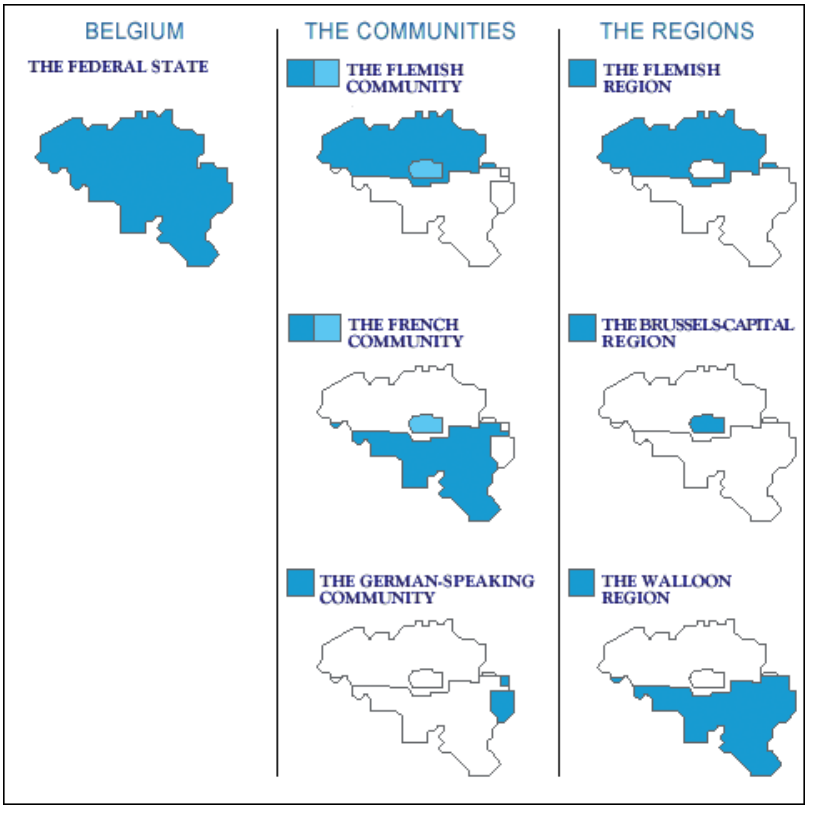
Appendix 1: Make-up of the Belgian Federal State



France

1 Demography

France is a western European country with an area of 675 417 square kilometres, including the overseas territories. Its capital is Paris and its population was estimated to be 64 473 140 in January 2008 (61 875 822 excluding the overseas territories). The country is divided into 22 regions and 100 *départements* (96 excluding the overseas territories). The official language is French and the currency has been the euro since 2002. France is a constitutional republic. The president of the republic is elected by direct universal suffrage and appoints a prime minister to conduct the policy of the government, whose actions are overseen by the parliament (comprising the Chamber of Deputies and the Senate). The economy is mainly based on the service sector (which employs three quarters of the workforce), a substantial part of which is accounted for by tourism. France is the second biggest exporter of agro-foodstuffs in the world. Its industry is based on a number of sectors (transport, cars and energy).

2 Epidemiology

Three types of substances are considered legal and may therefore lawfully be used in France: tobacco, alcohol and prescribed medicines. However, medicines are sometimes misused. France is one of the largest consumers of medicines in the world, and the leading consumer of psychotropic drugs. It is near the top of the list of European countries for the consumption of tranquillisers and sleeping pills among 16 year-olds: 13% of French teenage schoolchildren say they have used psychotropic drugs at least once without a prescription. France comes third in this respect, after Poland and Lithuania.

The use of all other substances (including poppers since 2007) is illegal and their production, import, distribution and use are punishable (prison sentences, fines, treatment orders, awareness courses, etc.).

Cannabis is the most widely used illegal substance: 4 million people have tried it and there are 1.2 million regular users and 550 000 daily users (including 380 000 under the age of 25). One in two 17 year-olds claims to have tried it. Regular consumption, although much less common than experimental use, has been rising since 2000. 2.3% of adults aged 18 to 75 and 10.8% of 17 year-olds are concerned. As is the case with all illegal products, more men than women use cannabis (3.7% as against 1%).

As for alcohol, one third of the people aged 12-75 who were surveyed had drunk at least six glasses on a single occasion at least once during the

previous year, and 30% smoked tobacco from time to time. Regular drunkenness has been on the increase among young people for a few years now. In 2005, 27% of 17 year-olds said they had been drunk at least three times in the course of the year and 9% of them at least 10 times over the same period. The proportion of young people aged 18-25 who say they have a problem with alcohol is estimated at 10%.

2.1 Experimentation

The substances most often experimented with – at least once in a lifetime – are alcohol (85% of people aged 12-75), tobacco (57% of people aged 12-75 have smoked at least once) and cannabis (31% of people aged 15-64). Experimentation with other substances is much less common (poppers 4%, hallucinogenic mushrooms 2.7%, cocaine 6%, inhalants 1.7%, amphetamine and LSD 1.6%, heroin and crack <1%).

Experimentation with cocaine (a least a once in a lifetime) is relatively uncommon among the population at large in France, even though it is one of the most widely used illegal drugs after cannabis. Of people aged 15-64, 2.6% have tried it. More men (3.9%) than women (1.6%) experiment with cocaine. Although only a tiny fraction of the population is concerned, cocaine use increased during the 1990s, rising from 1.2% in 1992 to 3.8% in 2005 in the 18-44 age bracket.

It is mainly young adults who experiment with cocaine, in particular those in the 26-44 age-group (3.9%), while the proportion in the 18-25 age bracket is 3.4% and in the 45-64 age-group it is 1.3%. It is estimated that about one million people in France in the 12-75 age bracket have experimented with cocaine, and the number of users in the course of the year was about 200 000.

Among 17 year-olds, 2.0% of girls and 3.0% of boys experimented with cocaine in 2005. These figures are markedly higher than those reported in 2003, the date of the previous Escapad survey, among both girls (1.1% in 2000) and boys (2.0% in 2000). The figures for recent use are still relatively low: 0.9% of 17 year-olds had taken cocaine during the previous 30 days (0.7% of girls and 1.2% of boys).

The proportion of people who have experimented with heroin (taken it at least once in their lives) among the population at large in France is low, no more than 1%, whether in the 15-34 age bracket (0.9%) or the 35-64 age-group (0.7%). The figure seems to have been stable since the early 1990s. It is estimated that 400 000 people aged 12-75 in France have experimented with heroin. In 2005, among 17 year-olds, 0.6% of girls and 0.8% of boys had tried heroin. These figures seem to have been stable since 2000.

Overall, experimentation with hallucinogenic mushrooms is uncommon among the adult population in France (2.7% of people aged 15-64). A higher proportion of young adults (3.7% of people aged 15-34) than middle-aged people (0.5% of people aged 55-64) appear to have tried them. It is estimated that about 1.5 million people aged 12-75 have tried hallucinogenic mushrooms at least once in their lives, and about 200 000 people have taken them in the course of the year. The frequency of experimentation with LSD among the population at large is relatively low (1.1% of people aged 15-64). A distinctly higher proportion of young adults (3.7% of people aged 15-34) than middle-aged people (0.5% of people aged 55-64) have tried them. The number of people aged 12-75 who have taken LSD at least once in their lives is estimated at about 700 000, and the number who have taken it in the course of the year at fewer than 200 000. The level of LSD use in the adult population appears to have been stable since the early 1990s.

The level of experimentation (at least once in a lifetime) with poppers among the population at large is still relatively low in France, even though they are the most widely consumed illegal drug after cannabis: 4.1% of people in the 15-64 age bracket have taken them. More men (6.0%) than women (2.2%) have tried them. Experimentation is highest among young adults, in particular those aged 18-25 (5.6%), and in the 26-44 age bracket (6.3%), whereas only 0.9% of people aged 45-64 have tried them. In France, in the population at large, relatively few people have experimented with inhalants (such as solvents and glue), that is, have used them at least once in their lives: 1.8% of people aged 15-64. More men (2.6%) than women (1.0%) have tried inhalants, which appeared to be used slightly less frequently than in the early 1990s.

2.2 Consumption over the year (2005)

In the course of the year, 200 000 people aged 15-39 (out of 20 million) took cocaine, more than in 2000. More men than women use it (1.4% as against 0.6%).

Of those aged 15-39, 0.5% or 180 000 people out of 20 million, took ecstasy in the course of the year. The proportion who took heroin is 0.2%, or 40 000 people.

2.3 Treatment (2005)

In 2005, 45 000 to 50 000 users were seen in the course of the year in specialist centres; 35 000 cannabis users were received in specialist units.

Of the 35 000 people received in 2005, about half were seen at the 280 "young users' units", most of which are attached to centres specialising in the outpatient treatment of drug addicts (of which there were 217 in 2005). More than half the people who came to the units because of a problem with

cannabis had been sent by the courts. Over 80% of the people seen for a cannabis problem were male. The number of cannabis users seen by these units has risen sharply over the last 10 years.

With regard to people dependent on opiates, the quantities of opiate substitution products sold correspond to treatment for about 100 000 patients for a year.

2.4 Morbidity

In 2004, it was estimated from a survey of 1 462 users that 59.8% (50.7-68.3) of them were suffering from hepatitis C and 10.8% (6.8-16.6) were HIV-positive (Coquelicot survey).

2.5 Mortality

The official figure for deaths from overdoses was 176 in 2006. This is a minimum estimate.

3 Background

In France the work of the ministries involved in combating drugs and preventing addiction is co-ordinated by an interministerial body, the Mission interministérielle de lutte contre la drogue et la toxicomanie (MILDT – the Interdepartmental Mission for the Fight against Drugs and Drug Addiction), under the authority of the prime minister. The MILDT's remit now covers all illegal drugs and abuse of, and dependence on, alcohol and tobacco. The MILDT relies on work carried out and data collected by a public-interest body, the Observatoire francais des drogues et des toxicomanies (OFDT – French Drugs and Drug Addiction Observatory), for official scientific data and in order to find out as much as possible about the level of use and treatment, the health and social consequences and trafficking.

In conjunction with the various ministries concerned, the MILDT recently drew up a new government plan for combating drugs and drug addiction for the period 2008-2011. The plan, approved by the government on 8 July 2008, sets the government's priorities up till 2011. It incorporates the Ministry of Health's treatment and prevention plan for 2007-2011.

In the light of the assessment of the 2004-2008 plan and consultations with the main associations concerned, the new government plan includes 69 measures concerning treatment and the reduction of risks associated with drug use, out of a total of 193 measures. It provides for the further development and diversification of medical and social facilities for the treatment of addiction. Measures include:

– training for all health professionals in the early identification of addiction, so that this becomes a natural reflex;

- targeting of the most exposed and vulnerable sections of the population:
  - an increase in accommodation capacity by virtue of a partnership between treatment units and the temporary social housing authorities, targeting the most vulnerable sections of the population, including women with children and people coming out of prison;
  - improved measures to deal with those people coming out of prison who are the most destitute through the establishment in each prison catchment area of short-term (two months) accommodation and care facilities that serve as a half-way house for those leaving prison;
  - improved care for prisoners through the establishment of new drug addiction units;
  - establishment of new therapeutic communities;
  - an increase in the number of young people seen by young users' units through improved geographical coverage and facilities for catering for multiple addictions (in particular, alcohol and cocaine);
  - improved prevention and treatment of drug and alcohol use among pregnant women;
  - development of new means of treating cocaine users, based on a frame of reference approved by the Haute Autorité de Santé (Supreme Health Authority);
- pursuit of the policy of risk reduction among users of illegal drugs, with stronger measures to prevent hepatitis C;
- emphasis on research, in order to come up with means of treating forms of addiction that are spreading and for which no real treatment is available (cocaine, crack, etc.).

4 Organisation of treatment services

Arrangements for the treatment and care of users of illegal drugs are threefold, comprising specialist addiction treatment centres (medico-social establishments), general services (hospitals and general practitioners) and the risk reduction scheme.

4.1 Specialised services

Since the early 1970s, specialist units have been responsible for treating addiction to illegal drugs. These units were further developed in response to the 1970 Act, which included provisions guaranteeing anonymous treatment, free of charge, for all users of illegal drugs who wanted to be treated. Virtually all French *départements* now have at least one specialist drug addiction treatment centre (c*entre de soins spécialisés pour toxicomanes* – CSST).

These centres, which were originally financed by the state and have been funded since 1 January 2003 by the social insurance schemes as medico-social establishments, seek to combine medical, social and educational care, including assistance with integration or rehabilitation. Every CSST must be able to meet express requests from people wishing to remain anonymous and receive treatment free of charge, as provided for in Articles L3414-1 and L3411-2 of the Public Health Code. Most of the CSSTs are run by non-profit-making organisations, but some are attached to hospitals.

There are three types of CSST:

– outpatient centres (of which there were 209 in 2005);
– inpatient centres (of which there were 41 in 2005);
– centres in prisons (of which there were 16 in 2005).

Outpatient CSSTs meet requests from patients who want to be weaned off drugs as outpatients. They can also make arrangements and provide support for patients who want to undergo detoxification in hospital. As for substitution treatment, doctors practising in a CSST were, from 1993/1994 until quite recently (2002), the only people authorised to put methadone treatment in place, after which repeat prescriptions could be issued by doctors in private practice. Patients may also have access to high dose buprenorphine (trade name Subutex®) in a CSST. Furthermore, patients may obtain support, psychotherapy and help with social rehabilitation at the centre.

Under Decree No. 2007-877 on the tasks of addiction treatment, support and prevention centres (*centres de soins d'accompagnement et de prevention en addictologie* – CSAPAs, NOR: SANP0721630D), published on 14 May 2007, outpatient and inpatient CSSTs and CCAAs (*centres de cure ambulatoire en alcoologue* – outpatient alcohol addiction centres) will be grouped together under the title of addiction centres and will cater for all types of patients. In theory, the CSSTs and CCAAs are required to receive anyone with an addiction to a psychoactive substance. In practice, however, the two types of specialisation and treatment can be expected to persist.

Circular No. DGS/MC2/2008/79 of 28 February 2008 concerning the establishment of addiction treatment, support and prevention centres and regional medical and social strategies for tackling addiction:

– sets out the arrangements for converting specialist drug treatment centres (CSSTs) and outpatient alcohol addiction centres (CCAAs) into addiction treatment, support and prevention centres (CSAPAs);
– explains the tasks of these new establishments;
– sets out the regional medical and social strategies for tackling addiction.

As part of the 2004-2008 government plan for combating illegal drugs, tobacco and alcohol, units where young users of cannabis and other

psychoactive substances and their families may obtain help have been set up to assist young people experiencing problems because of their use of psychoactive substances. Most of the 280 young users' units are part of the new CSAPA outpatient set-up (there were 217 CSAPAs in 2005). One of the appendices to the above-mentioned circular concerns the young users' units, whose terms of reference have been changed.

Circular DGS/MILDT/SB6B/2006/462 of 24 October 2006 (NOR SANP0630464C) on the establishment of therapeutic communities, in accordance with the 2004-2008 government plan for combating illegal drugs, tobacco and alcohol, sets out arrangements for the establishment and approval of therapeutic communities with a view to diversifying the facilities available. These communities are defined as "units catering for users dependent on one or more psychoactive substances, for the purposes of their achieving abstinence, where the distinctive feature is that the group is at the heart of the therapeutic and social integration strategy".

Therapeutic communities are "experimental" establishments which should eventually (after three years, once they have been evaluated) be classified as medico-social establishments. Unlike the CSAPAs, they offer long-term accommodation (one year, extendable to two years) and treatment, including a community-based cognitive-behavioural approach in which peer influence plays a part.

4.2 General services

The specialised care set-up cannot meet all the treatment needs of users of illegal drugs. In the 1990s the focus was on improving facilities for patients with addiction problems in the general care system (hospitals and general practitioners).

In hospitals (health care establishments), treatment of addiction is based on consultations with addiction specialists, addiction liaison and care teams, the hospital's urban network of partners and the provision of hospital beds to wean patients off drugs and carry out medical, psychological and social assessments.

The addiction liaison and care teams set up further to the circular of April 1996 normally comprise three people, including a hospital doctor. Their purpose is to train and assist the hospital care teams, devise treatment and care protocols and deal with people in hospitals and casualty departments. The teams must also establish links with the treatment facilities to allow for the medical, psychological and social monitoring of patients. They conduct prevention, information and awareness campaigns within the hospital. In 2003, about 100 health care establishments had active liaison teams. Their work is, however, largely devoted to alcohol and tobacco addiction problems.

Since 2002, any doctor working in a health care establishment has been authorised to prescribe methadone (Circular No. DGS/SD6B/DHOS/O2/2002/57 of 30 January 2002 concerning the prescription of methadone by doctors in health care establishments for the purposes of putting in place substitution treatment for addicts heavily dependent on opiates). This possibility is also available to doctors in outpatient consultation and care units (UCSAs), regional medico-psychological services (SMPRs) and psychiatric units in prisons.

The 2007-2011 plan for treating and preventing addiction, drawn up by the Ministry of Health, provides, over the period covered by the plan, for the organisation of health care units at three levels: local, referral and reference.

The local level comprises:

– addiction consultations in hospitals, covering in particular consultations for addiction to tobacco, alcohol and drugs and forms of addiction not involving a substance;

– a hospital liaison team, whose tasks, as defined in the Hospital Directorate Circular of 8 September 2000, are to identify patients in difficulty while they are in hospital and refer them for suitable treatment.

The aim is to have a consultation facility and liaison team in all health care establishments equipped with a casualty department, as specified in the decree of 22 May 2006.

The referral level consists of hospital admission facilities with staff trained in addiction, offering specific forms of treatment. They receive patients whose state of health require specialist treatment in hospital. In addition to consultations and the services of the liaison team, they offer:

– day hospital facilities;

– full hospital admission for simple (stays of about seven days) or complex (prolonged stays) detoxification treatment.

The reference level consists of addiction centres in teaching hospitals comprising both referral facilities, as described above, and a regional reference, training and research centre. They allow co-ordination between the clinic and institutional research facilities – INSERM (National Health and Medical Research Institute), the CNRS (National Scientific Research Centre) and those involved in pure research. The centre works in conjunction with other parts of the hospital, in particular the pharmacodependence evaluation and information centres.

The advantage of this three-tier organisation of health care facilities is that it puts the emphasis on the importance of geographical coverage and ensures that health care is available as close to the population as possible and is

adapted to the complexity of requirements stemming from the seriousness of the addiction and other illnesses from which the patient suffers.

Hospital networks of urban partners were also set up further to the circular of 3 April 1996. In 1998 there were 67 such networks, spread throughout the country; in 2002 there were 114 addiction networks, or 107 if the overseas territories are excluded. They are financed jointly through sickness insurance scheme funds and government funds.

General practitioners now play a key role in France in prescribing opiate substitution treatment. Since 1996 they have been allowed to put high dose buprenorphine treatment in place for patients dependent on opiates. They may also prescribe methadone after learning about the treatment in a CSST, hospital or prison.

General practitioners are also the first people to be able to intervene in the case of patients starting to take illegal drugs. The authorities therefore plan to introduce training for general practitioners to encourage identification of drug use and the provision of appropriate treatment.

It emerged from data from the sickness insurance schemes in 13 towns that about 35% of general practitioners had prescribed substitution treatment in the second half of 2002. Very often, however, a small number of doctors are largely responsible for prescribing such treatment, whether based on methadone or high dose buprenorphine.

The development of hospital networks of urban partners dealing with addiction, which were set up on an administrative basis in 1996, met the need for multidisciplinary work for the purposes of organising specific training for the various parties involved in providing care, and improving the care of drug addicts throughout their treatment, particularly by providing earlier access to treatment. This approach makes it possible to take account of the various aspects of patient care and at the same time to provide training for the parties involved and an opportunity to meet and discuss matters.

The hospital networks of urban partners are led by general practitioners, hospital practitioners and other parties involved in treating drug addiction in the same region and are responsible for liaison and the continuity of care in the different services dealing with drug addicts. Pharmacists in private practice are also increasingly involved.

4.3 Risk-Reduction Scheme (RDR)

A first step forward was taken in 2004 with the legal recognition of the RDR. The Public Health Act passed by parliament in 2004 officially made the RDR an integral part of public health policy in the field of addiction (L.3121-3 to 5 of the Public Health Code). This was an important development because,

for the first time, it gave France an indisputable legal basis for risk-reduction measures, provided they were in keeping with the objectives of the act.

The second stage came in 2005 with the formulation of a national frame of reference for risk-reduction measures. The MILDT was a driving force for the preparation of this reference document, which was produced in close consultation with those involved on the ground (professionals, associations, elected representatives, etc.) and the various ministries concerned. The aim in devising the risk-reduction frame of reference was to ensure that the content was such as to forestall any attempts to call it into question by those who were afraid that it would encourage people to take drugs. It is designed to facilitate dialogue with all the parties concerned, including law-enforcement agencies, when difficulties arise while action is being taken on the ground. It is also intended to promote good risk-reduction practices. The national frame of reference was published in the Official Gazette in the form of a decree (Decree No. 2005-347 of 14 April 2005).

The CAARUD decree of 19 December 2005 provides a legal framework for teams working on the ground and ensures that they are funded by the sickness insurance scheme. The decree is supplemented by Circular No. DGS/S6B/DSS/1A/DGAS/5C/2006/01 of 2 January 2006 on the organisation of the risk-reduction scheme, the establishment of reception centres providing support for drug users for the purposes of reducing risks (CAARUDs – *centres d'accueil et d'accompagnement à la reduction des risques pour usagers de drogues*) and the funding of the centres by the sickness insurance scheme.

5 Services

5.1 Detoxification

Hospital addiction services and hospital departments are not specialised in addiction, such as psychiatric, internal medicine and infectious diseases departments (dealing with patients infected with HIV or hepatitis C).

5.2 Evaluation/planning of treatment

Various institutions are involved in planning and evaluating treatment:

- Ministry of Health – Directorate General of Health/Addictive Practices Office;
- Ministry of Health – Hospitalisation and Care Organisation Directorate;
- Decentralised Ministry of Health services:
  - regional directorates of health and social affairs (DRASSs)/regional medical and social addiction strategy;
  - *département* directorates of health and social affairs (DDASSs)/accreditation of medico-social facilities;

  - regional hospitalisation agencies/regional strategies for the organisation of addiction care;
- OFDT (French Drugs and Drug Addiction Observatory): provides *département*, regional and national indicators;
- Institut de Veille sanitaire (InVS – Health Watchdog): produces studies on the health of drug users, particularly in respect of HIV and hepatitis B and C ;
- *Département* inter-ministerial committee under the authority of the person in charge of the drugs and dependency strategy, who is responsible for applying the various aspects of the government plan (prevention, law enforcement, care and risk reduction) in the *département* and managing the decentralised budgets of the MILDT, working in conjunction with the drugs and dependency co-ordinator, who is usually attached to the DDASS.

5.3 Treatment

5.3.1 Opiate substitution treatment

Opiate substitution treatment is relatively recent in France (dating from 1993) and was prompted by the need to address the HIV epidemic and the large number of fatal overdoses.

In 1995 doctors in private practice were authorised to prescribe methadone substitution treatment (once they had been introduced to the treatment by a specialist establishment).

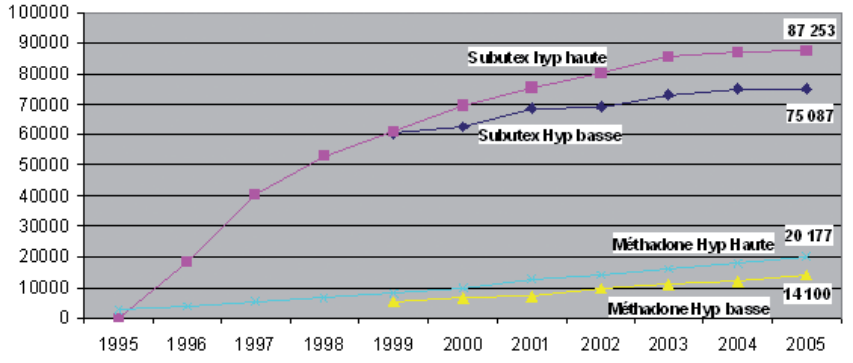
As it was observed that access to substitution treatment in specialist centres was insufficient to meet demand, a parallel form of treatment based on high dose buprenorphine was introduced in 1996. The arrangements for introducing doctors to the treatment and prescribing it are more flexible than in the case of methadone: the drug may be prescribed by any doctor, with no special conditions, for a maximum, non-renewable period of 28 days. The drug is delivered in instalments, every seven days, unless otherwise specified.

Alongside the benefits observed since the introduction of substitution treatment (a favourable health and social impact), undesirable consequences have been observed, almost exclusively related to high dose buprenorphine. Misuse is mainly due to the flexible arrangements for prescribing the product: the high dose buprenorphine may be injected, even in the case of patients under medical supervision (this may lead to abscesses and expose them to the risk of contamination with HIV and hepatitis C); it may be used in a manner not provided for in the medical protocol (not for substitution purposes), or in combination with other substances (benzodiazepines, alcohol, cocaine, etc.); and there have been cases of trafficking, organised or otherwise.

It should be noted that since 2006 Subutex® has no longer been the only product available, as generic high dose buprenorphine drugs are now coming on to the market.

The quantities of opiate substitution drugs prescribed by doctors in specialist centres, in private practice and in hospitals make it possible to estimate the number of people prescribed substitution treatment for a full year in 2006 at between 76 000 and 89 000 in the case of high dose buprenorphine and between 14 000 and 16 000 in the case of methadone (see Figure 6). High dose buprenorphine therefore accounts for about 80% of substitution treatment. The proportion of patients receiving methadone was slightly higher in 2005 than in 2006. In fact, one of the recommendations of the June 2004 conference on substitution treatment was that access to methadone be facilitated.

Figure 6: Opiate substitution treatment: number of drug users treated with high dose buprenorphine (Subutex®) and methadone – 1995-2005



Key: hyp haute = upper estimate; hyp basse = lower estimate
Sources : GERS/SIAMOIS/InVS and CNAMTS/OFDT estimates

It should be pointed out, however, that some of the buprenorphine prescribed is not used for the purpose for which it is intended, in that it is not always taken as a form of treatment. According to sickness insurance scheme data from 2002, it can be estimated that 65% of the 79 000 patients who received at least one prescription were undergoing medical treatment, 28% received substitution drug prescriptions irregularly and about 6% obtained prescriptions, usually from several doctors, with a view, in some instances, to reselling the product.

In the specialist care centres, an average of nearly 80 patients per centre received a methadone prescription, slightly more than in 2004. The 2005

figures seem to show an increase in the prescription of substitution treatment, particularly methadone treatment. The total number of patients prescribed substitution treatment by a CSST in 2005 is estimated at about 36 000 (slightly over 19 000 in the case of methadone and nearly 17 000 in the case of HDB).

5.3.2 Detoxification treatment administered or monitored by CSST staff

In 2005 an average of nearly 16 patients per centre underwent outpatient detoxification at a specialist drug addiction centre, and nearly 10 patients underwent detoxification in hospital with support from a centre.

According to data provided by the CSSTs, the number of patients who underwent detoxification in 2005 may be estimated at about 9 000, compared with 7 500 in 2004. The increase is related to the rise in the average number of cases of detoxification in hospital and the growing number of cases dealt with in the centres, which are responsible for over 150.

5.3.3 Treatment of patients with multiple diagnoses

There is no service that specialises strictly in treating drug users who also suffer from psychiatric illnesses. Some psychiatric hospitals have, over the last few years, introduced facilities for dealing with drug addicts, but they are few in number. Since 1998, there have been three Directorate General of Health (DGS) circulars designed to improve such treatment, recommending increased co-operation among the services concerned (CSST, hospital psychiatric department, etc.), but collaboration still takes place only on an ad hoc basis.

People treated for heroin or cocaine addiction often have a history of psychiatric problems: in 2006, 29% of them had already been admitted to hospital on account of a psychiatric disorder. These people are even more socially and economically disadvantaged than the others.

5.3.4 Inpatient/outpatient treatment

It is difficult to make an accurate estimate of the number of users of illegal drugs (excluding cannabis) seen in specialist centres in the course of a year, as users are likely to attend several centres in the same year. It is estimated that between 45 000 and 50 000 users were seen by specialist centres in 2005.

As for cannabis, 35 000 users were received by specialist centres in 2005. The number has increased sharply since the late 1990s. The fact that cannabis accounted for a substantial proportion of requests for treatment in 2006 (46%) is partly explained by the fact that many CSSTs have set up specialist units for young users of cannabis and other substances (see below). There are 280 such units. The average age of these cannabis users is 24.3. The

majority (54%) say they use cannabis daily, 17% use it frequently (two to six days a week), 11% once a week or less and 18% only occasionally.

The second most common problem is the use of opiates, which 41% of people attending report as the main drug they use. Their average age is a little under 31 and 79% of them take heroin, less than 3% methadone and 18% other opiates (including high dose buprenorphine). Nearly 80% of opiate users take opiates daily and 11% frequently (several days a week). The opiates are mainly sniffed (52%) and injected (26%).

Cocaine is the third most widely used drug; its use is reported by 6.4% of patients. They have an average age of 32 and say they use the product every day (42%) or frequently (25%). The cocaine is mainly sniffed (51%) or smoked (36%), but an appreciable proportion of patients (12%) inject it.

As in 2005, the figures for 2006 highlight the fact that the people who attend CSSTs as outpatients are a very mixed group. Two main categories can be discerned, patients seen for problems with cannabis use and patients on opiate substitution treatment/problem users of opiates and/or cocaine.

5.3.5 Drug use and alcohol/prescribed drug abuse

Decree No. 2007-877 on the tasks of the addiction treatment, support and prevention centres (CSAPAs, NOR: SANP0721630D) was published on 14 May 2007. The decree provides for the CSSTs (specialist drug addiction centres) and CCAAs (outpatient alcohol addiction centres) to be brought together under the same name of addiction centre and to cater for all types of patients. In theory, the CSSTs and CCAAs are required to receive anyone addicted to a psychoactive substance. In practice, however, two types of specialisation and treatment can be expected to persist.

5.3.6 Psychiatric treatment

Area-based public-sector psychiatry comprises hospital treatment and non-hospital care (medical/psychological consultations). Access is free but waiting lists are sometimes long.

Private-sector psychiatry is also available but doctors in private practice are less inclined to receive patients considered as difficult.

5.3.7 Rehabilitation services (assistance with integration, etc.)

France has a rehabilitation and reintegration policy based, in particular, on the *département* integration schemes and contracts connected with the allocation of the *revenu minimum d'insertion* (minimum income allocated in order to facilitate integration).

Some opiate addicts have, by virtue of their inclusion in a scheme including substitution treatment, been able to become integrated or reintegrated in the community and to find jobs.

There are, however, too many who cannot be catered for by the rehabilitation facilities (those with a long history of exclusion and younger people on the fringes of society who abuse psychotropic drugs and are at risk of exclusion).

The national body responsible is the Directorate General of Social Affairs, which covers both health and employment.

Rehabilitation is organised by associations operating mainly with government subsidies or funding from the municipal authorities or *départements*.

5.3.8 Treatment of young people

In 2005, some 15 200 patients under the age of 25 were seen in 95 separate outpatient CSSTs, 15 inpatient centres and two CSSTs in prisons. They accounted for 34% of all people seen by these centres, as described above.

In accordance with the 2004-2008 government plan for combating illegal drugs, tobacco and alcohol, 280 "young user's units" have been set up. They cater primarily for young people, including minors, who feel that their use of psychoactive substances is causing problems. The aim is to take action at the very early stages of drug use (occasional use, harmful use). The units receive people who turn up spontaneously or are sent by a third party (their family, a health professional, their school or a court) because they have problems caused by the occasional use, risky use or harmful use of psychoactive substances. Most of the young user's units are attached to specialist outpatient drug addiction centres (of which there were 217 in 2005). An initial assessment of this set-up shows that the people who are supposed to be most exposed to the risk of becoming cannabis users (and particularly those liable to indulge in harmful use or become dependent) do indeed attend the centres: nearly 9 in 10 users are under the age of 25, with boys accounting for 80% of those attending. Of those attending, 38% are referred by a court, which means that court referrals are the leading reason for attending, although this applies much more to boys (42%) than to girls (19%).

5.4 Gender issues

5.4.1 Pregnant women/families with small children

All the outpatient and residential specialist centres financed by the sickness insurance scheme are mixed. Specialist drug addiction centres (CSSTs and CSAPAs) run special schemes for women, women with children and couples on both an outpatient and a residential treatment basis and in foster families.

One of the four experimental therapeutic communities that have been set up offers facilities specifically catering for women with children.

In the hospital system:

– some maternity hospitals have beds set aside for pregnant women with addiction problems;
– some maternity hospitals provide psychiatric and addiction treatment and have budgets earmarked for the purpose;
– there are "level-3" maternity hospitals specialising in high-risk pregnancies where women with a serious addiction problem may be identified at an early stage and given specialist treatment, but there is inadequate co-ordination between the addiction professionals and the obstetricians, midwives and paediatric nurses.

It seems that female drug addicts, in particular heroin addicts, often suffer from amenorrhoea, as a result of which a pregnancy is generally diagnosed late, often after the fourth month. Socio-economic problems, an unstable lifestyle, exclusion and a lack of interest in their health often also account for the frequent lack of antenatal care. Many pregnant drug addicts do not see a doctor until they give birth.

5.4.2 Other gender issues

Fewer women use psychoactive substances, with the exception of prescribed drugs

More men than women regularly consume alcohol and use cannabis: in 2005, three times fewer women than men said they regularly drank alcohol and used cannabis (see Table 8). The discrepancy is much smaller in the case of tobacco, although slightly more men than women smoke.

Table 8: Regular use of psychoactive substances according to sex among people aged 18 to 64 (%)

	Men	Women	Total	Sex ratio
Tobacco	33.5	25.6	29.5	1.3***
Alcohol	28.6	9.7	18.9	3.0***
Psychotropic drugs (in the course of the year)	13.8	24.3	19.3	0.6***
Cannabis	4.2	1.2	2.7	3.5***

Key: Regular use: alcohol drunk at least three times a week; daily smoking; sleeping pills, tranquillisers or antidepressants taken in the course of the year; cannabis used at least 10 times a month. ***: significant difference between the sexes (p>0.001).
Source: Baromètre santé 2005, INPES

Experimentation with drugs also appears to be more common among men, as is shown by the sex ratios (see Table 9 below). With the exception of amphetamine, for which there is no significant gender difference, two to three times more men than women experiment with illegal substances.

Table 9: Experimentation with the main illegal drugs according to sex among people aged 18 to 64 (%)

	Men	Women	Total	Sex ratio
Cannabis	38.5	23.3	30.7	1.7
Poppers	6.0	4.1	2.0	1.5
Cocaine	4.1	1.6	2.8	2.6
Hallucinogenic mushrooms	4.3	1.4	2.8	3.1
Ecstasy	3.1	1.0	2.0	3.1
Glue and solvents	2.6	1.0	1.8	2.6
LSD	2.6	0.6	1.6	4.3
Amphetamine	2.0	1.0	1.5	2.0
Heroin	1.3	0.4	0.9	3.3

Source: Baromètre santé 2005, INPES

It is likely that the use of amphetamine in the past as an appetite suppressant was more common among women, which would explain why the gender discrepancy is smaller than in the case of other substances. In the case of cannabis, the ratio rises with the increase in frequency of use, which shows that although men are indeed initially more likely to experiment with cannabis than women, the discrepancy increases as the practice continues and intensifies. The most "male" drugs are hallucinogenic substances (LSD and hallucinogenic mushrooms), as men are probably more interested in experiencing a state of altered consciousness.

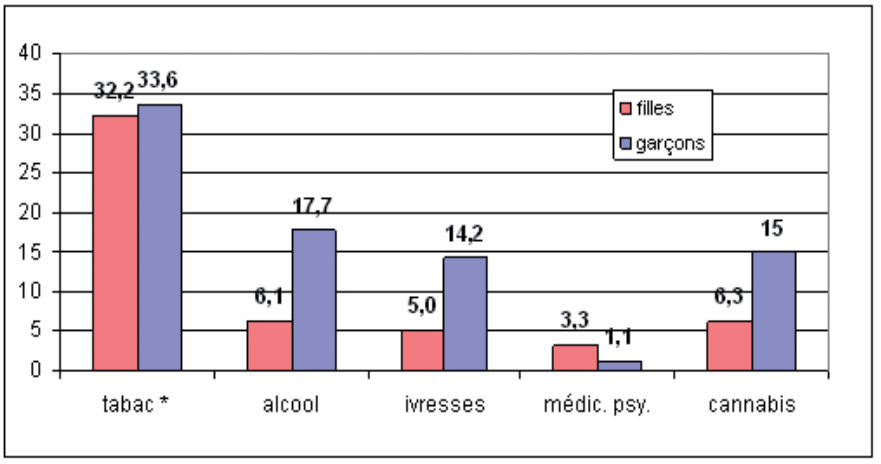
Girls are more likely than boys to sniff, eat or drink drugs and less likely to inhale or smoke them.

Use among young people

As in the case of adults, tobacco is the psychoactive product for which use differs least from one sex to the other: the levels reported by teenage girls are similar to those reported by boys. In the case of alcohol, drunkenness and cannabis, gender differences are more marked, with boys often more

concerned than girls (see Figure 7). As is the case with the adult population, girls take more prescribed psychotropic drugs.

Figure 7: Frequency of regular use (at least 10 times a month) among French 17 year-olds in 2005 (%)



Key: tabac = tobacco, alcool = alcohol, ivresses = drunkenness, médic.psy. = prescribed psychotropic drugs, filles = girls, garçons = boys
Source: ESCAPAD 2005, OFDT

Women are less often treated in specialist addiction centres

Far fewer women than men seek help in centres specialising in the treatment of people with addiction problems. Of the patients who began treatment in 2006 in outpatient CSSTs, 80% were male. This average seems to conceal certain gender disparities relating, in particular, to the substances used and practices. For instance, cannabis accounts for a smaller proportion of girls' requests for treatment and opiates, cocaine and prescribed psychotropic drugs a higher proportion.

Percentage of women treated in CSSTs and CCAAs

In specialist drug addiction centres (CSSTs), the percentage of women is nearly 15% when cannabis is the main substance used and 22% in the case of opiates, cocaine and other, rarer substances. In the outpatient alcohol addiction centres (CCAAs), which deal almost exclusively with people with alcohol problems, women represent slightly less than a quarter of the people attending (see Table 10).

Table 10: Breakdown of patients seen in CSSTs and CCAAs in 2005 according to sex (%)

	CSSTs Cannabis	CSSTs Opiates, cocaine and other substances	CCAAs
Men	85.3	78.2	75.9
Women	14.7	21.8	24.1
Total	100.0	100.0	100.0

Source: OFDT/RECAP 2005

Characteristics of women treated in CSSTs and CCAAs

Women treated for a cannabis problem are roughly the same age as the men, whereas in the case of opiates and/or cocaine they are slightly younger. In the CCAAs, the women seen are two years older than the men on average.

In contrast to the men, an appreciable proportion of the women live alone with their children: 7% in the case of cannabis users and 13-15% in the other two groups of women. The women are also more likely than the men to be living with a partner and less often completely on their own or living with parents.

The women are much less frequently referred to specialist centres by the courts than men, half as often in the case of cannabis, slightly less than half as often in the case of opiates and cocaine, and more than four times less often in the case of people seen by the CCAAs. They more frequently contact a specialist centre either on their own initiative or on the recommendation of a health professional.

A history of stays in a psychiatric hospital and attempted suicide are reported much more often in the case of women than men. The proportion of women with a history of stays in a psychiatric hospital and of suicide attempts is, respectively, two and three times higher among cannabis users. The difference is smaller in the case of the other two groups, but still substantial. Conversely, a history of imprisonment is very uncommon among the women and the proportion bears no comparison with the much higher figure for men (see Table 11).

Women are, however, observed to be more vulnerable (they may have been introduced to drugs by their partner, be victims of violence, etc.), according to an InVS (Health Watchdog) estimate of the prevalence of HIV and hepatitis C among drug users in France and its profiles of drug users (*Estimation de la séroprévalence du VIH et du VHC et profils des usagers de drogue en France*, InVS-ANRS, Coquelicot 2004).

Table 11: Breakdown of people seen in CSSTs and CCAAs in 2005 according to sex and substances used, in terms of certain characteristics (in years in the case of age and as a percentage in the case of the other characteristics)

	CSSTs Cannabis users		CSSTs Users of opiates, cocaine and other substances		CCAAs Consumers of alcohol	
	Men	Women	Men	Women	Men	Women
Average age	23.3	23.7	32.8	31.7	42.3	44.6
Living alone with children	0.5	6.6	1.1	14.7	1.7	13.5
Living with a partner, without children	6.6	12.9	12.2	18.0	21.1	26.7
Living with parents	60.6	41.7	26.6	18.1	14.0	5.9
Referred by the courts	54.5	25.8	12.7	5.0	31.7	7.4
History of hospital stays	12.3	24.1	28.1	36.1	21.8	35.0
History of suicide attempts	7.9	24.4	20.9	36.2	39.1	62.7
History of imprisonment	13.9	2.8	46.0	17.0	26.3	3.5

Source: OFDT/RECAP 2005

5.5 Treatment in prison: organisation and epidemiological data

5.5.1 Treatment facilities available in prisons

Since the Act of 18 January 1994, the organisation of treatment in prisons has been entrusted to the public hospital sector, which has the general remit of providing care for prisoners (somatic and psychiatric care, preventive measures, health education and preparation of supervision on their release), with due regard for the principle of equality of treatment in prisons and in the outside world. Each prison therefore has a Surgery and Outpatient Care Unit (UCSA – *unité de consultations et de soins ambulatoires*).

Of the 186 prisons in France, few have special facilities for treating drug addicts. There are drug addiction units in 16 major prisons. Care units for prisoners about to be released (UPSs), specialising in preparing drug addicts to leave prison, were set up in seven prisons on an experimental basis in 1997 (two closed in 2003).

An interministerial memorandum of 9 August 2001 reviewed the guidelines for the treatment of prisoners with addiction problems, focusing on five main measures:

– systematic identification of all situations of abuse and/or dependency, regardless of the psychoactive substance, particularly by means of a

standard diagnostic tool known as the "mini-grade grid"; national and local training courses in the use of the grid were held in 2002;

- an offer of treatment adapted to the needs of the prisoner;
- preventive measures, particularly for the prevention of risks associated with substance abuse;
- encouragement of adjustments to sentences;
- preparation for release.

5.5.2 Care of addicts and treatment of dependency

Facilities for treatment in the strict sense of the term seem relatively satisfactory as regards specialist drug addiction consultations, which are available in nearly nine prisons in 10. The objective of systematically identifying cases of drug addiction is far from being achieved, however, with only 60% of prisons using specific identification tools (including the mini-grade grid) during the initial medical examination. In more than eight out of 10 prisons, the UCSA is responsible for identifying addiction on arrival.

The regional medical and psychological services (SMPRs – *services medico-psychologiques regionaux*) are responsible for providing psychiatric care in 26 (generally large) prisons. The 102 rehabilitation and probation prison services (SPIPs – *services pénitentiaires d'insertion et de probation*) help to achieve the objective of socially monitoring prisoners and ensuring their rehabilitation when they leave prison. They are responsible for the social rehabilitation of drug addicts (some of whom have begun treatment in prison) and, to this end, refer them to public-sector partners or associations.

It is theoretically possible to prescribe substitution drugs in prisons under the same conditions as outside, in order to put in place or continue treatment with methadone or Subutex®. All prisons are required to offer substitution treatment or detoxification to new arrivals who express the need for it (Circular DGS/DH/DAP of 5 December 1996).

The Ministry of Health has carried out four annual surveys of substitution treatment (March 1998, November 1999, December 2001 and February 2004), which show that, despite genuine progress, access to substitution treatment for prisoners addicted to heroin is more restricted than outside, although the proportion of the prison population receiving substitution treatment has increased: 2% in 1998, 3.3% in 1999, 5.4% in 2001 and 6.6% in 2004. The proportion interrupting substitution treatment on arriving in prison has fallen significantly, from 19% in 1999 to 5.5% in 2001.

The circular of 30 January 2002 authorises all doctors in health establishments to offer methadone substitution treatment to people seriously addicted to opiates. An evaluation of the effect of this circular by the OFDT (February 2008) points to observable improvements in access to methadone

and in medical practices in the services newly responsible for putting in place treatment of this kind, namely, hospital units and care units in prisons (UCSAs and SMPRs). The survey shows that access to methadone treatment has improved considerably, even though it is not yet universal: six years after the circular, half of the hospital units that prescribe substitution treatment and one third of medical services in prisons (excluding CSSTs) report that more than 50% of their patients are on methadone. Furthermore, the average levels of initial prescription in prisons are similar to those observed outside, which would seem to reflect a certain uniformity in the application of therapeutic guidelines. The progress that remains to be made therefore concerns the objective of extending access to methadone to all health establishments and ensuring greater continuity of care (particularly when prisoners are released).

6 Special issues in each country

The policy for combating drug addiction, which was introduced in the 1980s with a view to reducing risks by selling needles, took a big step forward when the medical and pharmaceutical profession were provided with two substitution drugs, methadone hydrochloride in 1995 and high dose buprenorphine in 1996.

There were different prescription and delivery rules for the two drugs – partly offset by the application of the regulations on narcotics to buprenorphine – not because of their regulatory status (narcotic as opposed to psychotropic drug) or their therapeutic indications, which are still similar, but because of their pharmacological action and therapeutic margin.

The provision of substitution treatment is part of a risk-reduction policy concerning drug users. The aim is, particularly through the provision of access to sterile injection equipment, to prevent the transmission of infections, deaths from overdoses of intravenously injected drugs and the social and psychological harm caused by addiction to substances classified as narcotics (Article L.3121-4 of the Public Health Code). The policy is designed more generally to provide access to treatment and social rehabilitation.

While the policy has had a considerable impact on the HIV epidemic and the number of fatal overdoses, it has been less effective in reducing the risks of contamination with hepatitis C, because of the prevalence of the virus and the fact that it is highly infectious. As part of this consolidated approach, the current challenges of the risk reduction policy are:

– to step up measures to prevent hepatitis C;
– to promote new practices and introduce new preventive measures in respect of festive occasions;
– to prevent people from becoming addicted in the first place by restricting trafficking in substitution products and other prescribed drugs.

The supply of psychoactive drugs is increasing and prices are falling steadily. As a result, nearly 1.2 million people regularly use cannabis, while the use of cocaine and synthetic drugs has doubled since 2002: there were 250 000 and 200 000 users respectively in 2005. It would also appear that regular drunkenness among young people has increased very substantially in recent years.

The facilities in place need to evolve and adapt to new patterns of use, with protocols and centres for treating users of cocaine in all its forms, early identification of, and guidance for, young users and new preventive measures, involving the adults responsible.

7 Strengths and weaknesses of the system

Strengths:

– accessibility and availability of opiate substitution drugs;
– very widespread availability of care (general practitioners, pharmacists, etc.);
– care available anonymously, free of charge.

Weaknesses:

– inadequate monitoring and evaluation of the facilities;
– problems with co-ordination between the health and social sectors and, within the health sector, between addiction and psychiatric services;
– access to substitution treatment still inadequate in prisons.

Germany

1 Demography

Germany, lying geographically in the centre of Europe and bordering Denmark, the Netherlands, Belgium, Luxembourg, France, Switzerland, Austria, the Czech Republic and Poland, has a total frontier of 3 757 kilometres. It is one of the founding members of the EU and is its most populous country with a population of 82 351 000 inhabitants; fewer than 10% are foreigners (7 289 000). The political and administrative system is of a strongly federalist character; 16 *Bundesländer* represent the regional distinctions (DeStatis, 2007).

The responsibility for drug and addiction policy is shared between the federal government and the *Länder*. According to the Basic Constitutional Law, the federal parliament has legislative authority over the narcotic drugs law, the penal law and the social welfare law. On this basis, it has defined a legal framework for its drug policy and has formulated specific standards. However, the implementation and execution of the federal laws mainly falls under the responsibility of the federal *Länder*. The *Länder* also have their own legislative authority in areas which are of relevance for drug and addiction policy including school, health and education systems. The actual implementation of the drug and addiction policy – in particular regarding the treatment system – mainly lies in the hands of the federal *Länder* and municipalities, which may very well set different focuses within the framework of given legal guidelines and common goals.

In Germany, health care and social work in particular are governed by the principle of subsidiarity and accordingly most competences with regard to counselling, care and general prevention activities lie within the joint responsibility of the federal *Länder* and the municipalities. Youth welfare relies on the joint work of governmental and non-governmental institutions according to the Social Code Book VIII, so any attempt to improve integration, for example between youth welfare and addiction support systems, or to change organisational structures, has to account for these different responsibilities. Hence, this tends to make supra-regional exchange of information and surveying of the overall situation more difficult in many cases.

Non-governmental organisations and private charity organisations in particular, organise by far the largest part of all specialised offers (e.g. sociotherapeutic care, counselling, specialised treatment) for drug users for which they receive public funding, from national, *Länder* and municipal budgets, as well as from health insurance and pension funds.

2 Epidemiology of drug use

The results of the last epidemiological survey conducted in 2006 corroborate the findings of earlier surveys, showing that about a quarter of the adult population in Germany has had experience with drugs. The portion of adults who took drugs in the last 12 months amounted to 5%; only about 3% used drugs in the last 30 days (Kraus et al., 2008). Prevalence among teenagers and young adults continues to be higher, but has also decreased compared to studies of previous years. In a representative national survey conducted in 2007, only 13% of 14-17 year-olds claimed to have smoked cannabis at least once in their lifetime compared to 22% in 2004. According to the most recent results, cannabis consumption among teenagers in the 11-17 age-group lies below 10% in the 12-month category.

Prevalence estimates of problem opiate use in Germany for 2000 varied according to the data selection source: from treatment data (absolute numbers: 166 000-198 000), police data (153 000-190 000) and mortality data (127 000-169 000) (Kraus et al., 2003). Recently updated estimates based on these figures indicate a decrease in problematic opiate use and the numbers range between 76 000 and 161 000 persons (0.1-0.3%) (Pfeiffer-Gerschel et al., 2007).

Of the clients who seek help from outpatient drug counselling facilities, 51% have a primary opiate problem and 31% suffer primarily from cannabis-related problems. Of those who are in therapy for the first time, 57% have cannabis-related disorders (opiates: 22%). In inpatient facilities, opioids continue to play a predominant role among illicit drugs. Here also, the number of cannabis cases is on the rise. In 2006, there was one cannabis patient compared to 2.4 patients with an opioid diagnosis (Sonntag et al., 2007a, 2007b).

According to the register held by the Federal Criminal Police, 1 296 people died of drugs in Germany in 2006. This is a slight decrease relatively to the previous year and a substantial decrease by almost 40% compared to the peak of 2 030 deaths in the year 2000. The cause of death was mostly related to opiates which were frequently used in combination with other psychotropic substances including alcohol.

As far as HIV-infection is concerned, according to the Robert Koch Institute, 6.2% (2005: 5.6%) of the people with an initial HIV diagnosis were part of the group of injecting substance users in 2006. Up to the year 2000, this value was still at 10.1% (2000: 170 of 1 688). Among other groups analysed, the portion of HIV-positive injecting drug users tended to be even lower still. Antibody prevalence (infection rate) of hepatitis B among injecting drug users in Germany can be estimated to range between 40% and 60% and for hepatitis C between 60% and 80% (Pfeiffer-Gerschel et al., 2007).

3 Short history of drug treatment

With regard to the development of drug treatment in Germany, the following milestones should be mentioned:

- In the 1850s the first treatment centres for alcoholics were established, since by that time the (ab)use of other psychotropic substances was very rare and the main focus of measures were for alcohol.
- After 1945 the traditional model distinguishing the provision of individual specialised addiction care and universal health care continued to be implemented.
- From 1960 the tendency was to implement more services offering individual specialised addiction care especially with regard to the problem of alcohol abuse.
- A verdict of the Federal Social Court (Bundessozialgericht) on 18 June 1968 recognised that addiction was a disease ("*Sucht ist Krankheit*"). This equalisation of addiction with other diseases had extensive consequences, for example addicts could raise a claim for appropriate treatment or their salary would be paid for a period of sick leave. In terms of content, physical dependence was distinguished from psychological addiction.
- In 1978, an agreement was reached between the health and the pension insurance funds regarding the funding of treatment and rehabilitation (*Empfehlungsvereinbarung*). Specifically, the costs of primary health care would be generally borne by the health insurance funds, whereas rehabilitation would be paid for by the pension insurance funds. The agreement was renewed in 2001.
- From 1980 there was a renaissance of the concept of public health; the new concept integrates both individual specialised addiction care and universal health care with the goal to create the conditions in which people could be and remain healthy. Within this framework, it is emphasised that individually targeted prevention and therapy are fundamental; although they could contribute only to a small extent in the reduction of the substance addiction problems in society.

In recent years, the term "drug policy" is undergoing a gradual change of meaning. Until the end of the last century, it was exclusively related to illicit drugs, which were at the centre of political interest. There was no comparable conception for a policy dealing with alcohol or tobacco, nor for an "addiction policy", comprising the whole range of addictive substances. Within the last few years, however, disorders resulting from licit psychotropic substances and common aspects of all addictive substances (e.g. in universal prevention or in patients with multiple abuse) have increasingly become the focus of political interest. This is the reason why the terms "drug and addiction policy" or "addiction policy" are used more frequently, gradually replacing

the term "drug policy". As a result of the changes in policy aims pursued and in strategies deployed in the area of licit and illicit substances, the usage of the term "drug and addiction policy" has become more and more prevalent in German.

Moreover, the range of vision is expanding from the original main focus on substance-related addiction to risky and harmful use, and thus to a comprehensive understanding of health policy for substance-related disorders and risks. However, the German language has no appropriate term reflecting the expansion of this concept, so that the (unsatisfactory) term of "addiction policy" continues to be used. The aforementioned changes in the drug policy are depicted in the treatment system developed in the country.

Today, Germany has an integral treatment system offering a wide range of support and treatment services, such as low-threshold facilities, different types of harm-reduction programmes as well as inpatient and outpatient treatment centres (Pfeiffer-Gerschel et al., 2007).

4 Organisation of treatment services

Outpatient counselling facilities offer contact, motivation and outpatient care. Withdrawal treatments/detoxifications are mainly done in general hospitals but also in a few specialised clinics. Rehabilitation can take place in special departments of hospitals, specialised clinics or therapeutic communities.

People willing to overcome their substance dependency with professional support are offered a wide range of counselling and therapeutic services. On the one hand, there are substitution offers with a target orientation aiming at reducing the use of drugs and stabilising the overall condition, and, on the other, abstinence-assisted treatment offers. The two concepts complement each other, since, in the long term, substitution too aims at abstinence from drugs, where possible.

Pharmacologically assisted substitution therapy offers are taken up by quite a large number of drug addicts. Since 2001, substitution therapy has been regulated in detail by the Narcotics Act and is meanwhile fully accepted as a medical therapy. Already in the year 2002, the Federal Medical Council passed comprehensive guidelines on the state of the art ("*BUB-Richtlinien: Richtlinien über die Bewertung ärztlicher Untersuchungs- und Behandlungsmethoden*"). In 2003, the national health insurance system acknowledged substitution therapy as a statutory health insurance (SHI)-accredited care service taking over the costs of therapy for the insured. The majority of patients in substitution therapy are treated by office-based doctors or in specialised outpatient facilities. Doctors providing substitution therapy need to be qualified in addiction medicine. If not, they can treat up to a maximum of three patients in consultancy with a qualified colleague.

Meanwhile, some inpatient facilities have also started to accept patients for substitution therapy. However, the status of integration between general health care and special drug care is still rather dissatisfying. At regional level, however, co-operation and co-ordination of the offers are clearly better. Medical substitution therapy should generally be accompanied by psychosocial care.

In 2006, a study on the use of heroin in the treatment of opiate addicts was successfully completed (see also Section 6 "Special issues"). As a result, the use of prescribed heroin (diamorphine) for regular treatment is currently under consideration. This kind of treatment is specifically tailored to a small cohort of patients who do not sufficiently profit from other therapy provision. The necessary legal changes and the definition of procedures, allowing for continuation of the treatment with diamorphine after the completion of the study, are currently still the subject of a political decision process.

Co-operation between different professional groups from social work/education, psychology and medicine forms a standard and integral part of addiction therapy. As for outpatient provision (outpatient treatment centres and others), quality assurance and technical monitoring are mainly the responsibility of the supporting organs of the facilities or respectively of the *Länder* and municipalities. Additionally, the responsibility for the respective regulations for medical treatment, such as detoxification and partly rehabilitation, are defined by insurance companies and pension funds. With outpatient treatment provision now increasingly funded by social security administration, the above-mentioned standards also gain in importance in this area.

In many *Länder*, co-operation between the different fields of work and organisations is promoted by *Länder*-financed institutions, such as, for example, the Bavarian Academy for Addiction (Bayerische Suchtakademie, BAS), the Hessian Regional Centre for Addiction Issues (Hessische Landesstelle für Suchtfragen, HLS) or the Thuringian Regional Centre for Addiction Issues (Thüringische Landesstelle gegen die Suchtgefahren).

5 Services

5.1 Detoxification

In Germany, detoxification is generally carried out in general hospitals, in specialised departments of psychiatric clinics or (more rarely) in specialised treatment institutions. The costs are normally covered by health insurance funds. It is generally carried out in inpatient treatment settings; although outpatient detoxification is also available in some cases. The duration of physical detoxification varies according to the substance, for example in the case of methadone and benzodiazepines six weeks or more are not unusual.

It should be noted here that not all detoxification options available are similar. The most widespread approach focuses mainly on physical withdrawal from the addictive substance. Nonetheless, there are also clinics offering a qualified withdrawal treatment, which comprises several additional elements beside the pure physical withdrawal. Within this framework techniques are applied to motivate patients to change their behaviour and a comprehensive assessment of the client's living circumstances provide the basis for possible subsequent long-term/rehabilitation treatment. Several social and psychological aspects of addiction are taken into account and treated accordingly.

In the withdrawal treatment for opiate addicts, methadone and buprenorphine are, among others, temporarily used to reduce negative concomitant symptoms. Because of minimal side effects and less severe withdrawal symptoms the latter is finding increasing usage. Statistical data on this type of treatment are not available in a differentiated form. However, the cases are recorded in the statistical hospital reports.

As far as the people undergoing substitution treatment are concerned, abuse of benzodiazepines is relatively common, among other substances, such as alcohol and tobacco. Therefore, inpatient withdrawal of benzodiazepines – in many cases in combination with other substances such as cocaine – is necessary for the success of substitution and in most cases also possible. However, unfortunately, many of the treated patients relapse within three months (Specka and Scherbaum, 2005). It is currently debated whether methadone-induced sleeping disorders could trigger the use of benzodiazepine (Elsner, 2006).

5.2 Evaluation/planning of treatment

Various professional societies and experts have worked together over the last few years to develop guidelines for the treatment of drug dependence and addiction problems. These publications are a condensed summary of the current state of knowledge and provide practical guidance for carry-ing out treatment of quality based on an empirical basis. Meanwhile, guidelines have been published for the acute treatment of opioid-related disorders (Reymann et al., 2003), for the post-acute treatment of opiate addicts (Havemann-Reinecke et al., 2004), for patients with cannabis-related disorders (Bonnet et al., 2004) as well as behavioural disorders caused by cocaine, amphetamine, ecstasy and hallucinogens (Thomasius and Gouzoulis-Mayfrank, 2004). In the year 2006, the Working Group of the Scientific Medical Professional Societies (Arbeitsgemeinschaft der medizinisch-wissenschaftlichen Fachgesellschaften, AWMF) published the guidelines drawn up by the AWMF on the diagnostics and therapy of substance-related disorders under the title "Evidence-based addiction medicine – treatment guide for substance-related disorders" (*Evidenzbasierte Suchtmedizin – Behandlungsleitlinie substanzbezogene Störungen*). The

evidence-based guidelines for the treatment of drug addicts provide for transparency and de-emotionalise the scientific controversies over the most efficient therapy approaches (Schmidt et al., 2006).

Moreover, the ASTO project encompasses quality assurance in outpatient substitution therapy of opiate addicts (Nolting and Folmann, 2005).

After several years of co-operation, a new core data set for documentation of addiction treatment was passed by the German Centre for Addiction Issues, the DBDD (German REITOX Focal Point), the umbrella organisations of addiction support in Germany and the *Länder* in 2006 and came into force in 2007. Based on a broad consensus procedure, this new German core data set contributes to uniform documentation standards which existed alongside one another at national level. A few new items were included in the core data set; others were modified or taken out. All in all, the new core data set succeeded in merging partly overlapping documentation standards and has been able to combine them into one single uniform standard. The treatment demand indicator (TDI) of the EMCDDA is also integrated into this core data set.

In addition to the above-mentioned core data set, a catamnestic module was passed to also provide outpatient facilities with the possibility of evaluating results at the end of therapy. A comprehensive manual was published aimed at providing definitions and classifying the items (www.dhs.de).

5.3 Treatment

5.3.1 Substitution treatment

Substitution has been the standard therapy for opiate addicts in Germany for many years. Since 1 July 2002, under the initiative and supervision of the Federal Centre for Drugs and Medical Devices (Bundesinstitut für Arzneimittel und Medizinprodukte – BfArM), data on substitution therapy was recorded in the substitution register to pre-empt double prescriptions of substitution drugs and to monitor the implementation of specific quality standards in therapy.

The most popular substances eligible for substitution therapy in Germany are levomethadone/methadone (approximately 81% of all registered cases in 2006) and buprenorphine (approximately 18%). Codeine and dihydrocodeine can only be prescribed in exceptional cases (<1%).[8] Use of buprenorphine has more than doubled since 2003, but methadone is still the predominant drug despite declining prescriptions.

8. The respective data have been provided by the Federal Centre for Drugs and Medical Devices (BfArM).

According to the aforementioned register of the BfArM, more than 6 626 doctors were licensed to carry out substitution treatment in Germany in 2007. However, the actual number of doctors with a respective supplementary qualification is presumably higher. Nonetheless, in terms of care, the fact that only 2 786 doctors reported substitution treatments to the substitution register in 2007, this is of much higher relevance. The number of substituting doctors without special qualifications fell from 153 in the year 2003 to 40 in 2006. In the year 2007, about 210 double substitution prescriptions were discovered by the substitution register. The doctors in charge were informed and the double treatments terminated.

Looking at the relation between reported number of patients on substitution and population figures in the individual *Länder* in 2006, the three city states Hamburg, Bremen and (at a considerable distance) Berlin are at the top of the list as expected. The lowest numbers of patients per inhabitant are reported by the three eastern *Länder* – Thuringia, Mecklenburg-Western Pomerania and (at a considerable distance) Brandenburg. With regard to Brandenburg, it is to be presumed that numerous users turn to the metropolis Berlin for substitution treatment (Federal Drug Commissioner, 2007, p. 48).

Generally, access to substitution treatment is particularly difficult in rural regions in the east of Germany. Only 2.7% (n=1.772) of the registered substitution patients and 3.4% of the doctors (n=93) in 2006 came from the eastern Länder (excluding Berlin).

5.3.2 Drug-free treatment services

Abstinence-assisted therapy is subdivided into four basic phases: contact and motivation phase, withdrawal phase, rehabilitation phase, and integration and aftercare phase.

Therapy is structured according to the above phase model. The goal of the contact phase is to develop, maintain and strengthen the motivation to have addiction treated. A help plan should be developed for the therapy which should start with counselling comprising medical, psychological and social diagnostics and case history. The help plan should take account of therapy and health care provision available at regional level in order to select the measures which are best suited for the individual case.

In the withdrawal phase, multi-professional teams assist in working on addiction with all its aspects in a “qualified withdrawal” programme. The duration of the withdrawal phase may vary, depending on the individual circumstances, between two to six weeks.

The goal of the rehabilitation phase is to stabilise the abstinence achieved in the detoxification phase and to put a definitive end to addiction.

Rehabilitation can be carried out in outpatient, inpatient or partly inpatient services. The standard therapy duration is six months.

The integration and after-care phase is a "phase of assimilation", in which individual therapeutic measures move into the background in favour of an outward orientation with a view to promote integration into work and society. In the integration phase, clients receive support from the special service departments of the job agencies as well as from the social security administration. Along these lines, a varied offer specifically geared to the needs of the clients is made with regard to employment, housing and reintegration into society. All fields of work are staffed with specialists who, for a major part, have received work-field-specific supplementary training (Pfeiffer-Gerschel et al., 2007).

5.3.3 Dual diagnosis treatment

Drug users who, in addition to their drug problems, suffer from psychiatric disorders which require treatment need help which takes both fields into account. These individuals depend in a special way on the general diagnostic competences of addiction therapists also in the field of psychological disorders, and, at the same time, require co-operation between clinical psychology/psychiatry and addiction treatment which is appropriate to tackle both types of problem. The issue being stated and described at many places does not mean that the practical consequences are always easy to implement in the field of everyday practice given the differences in work areas, responsibilities and methods of financing.

In practice, there are two ways of dealing with these problems: either the two problem areas are dealt with by two different therapists/institutions who/which have to closely co-ordinate their activities, or treatment is carried out at one place, though this requires competences in both problem areas. In general, mixing these clients with other drug clients has not proven positive, as clients with dual diagnoses sometimes require a slower and more flexible therapeutic approach (e.g. regarding medication, keeping agreements, accepting set structures) (ibid.).

5.3.4 In/outpatient

Outpatient counselling facilities are the first port of call for drug users in so far as their drug problems are not treated by office-based doctors in primary care. In most cases, counselling is free of charge. The facilities are mainly funded by the municipalities and the *Länder*.

If drug problems and concomitant symptoms are too problematic, consequences too massive or the general situation for the drug addict cannot be dealt with in an outpatient setting, the patient is admitted to inpatient therapy. However, the transfer from outpatient to inpatient therapy involves

some administrative work and it needs to be clarified who will take over the costs for inpatient therapy (generally the pension insurance fund, patients without employment are subject to other regulations). Sometimes inpatient therapy does not suit the client's situation – if, for example, existing employment would be jeopardised or no adequate care for the children of an addicted mother can be found. The transfer from outpatient to inpatient care also has the effect of a filter mechanism. Patients in inpatient therapy do not only differ from outpatient ones in the severity of the addiction problem but also in gender distribution. In general, inpatient treatment in Germany is carried out under drug-free conditions (ibid.).

5.3.5 Drug and/or alcohol and prescribed drugs

Most of the drug treatment in Germany takes place in centres and institutions which deal with dependence in general, although there are also treatment units for illicit drug users only. Nonetheless, inpatient treatment centres tend to be specialised with regard to the target group they address (legal or illegal substances abuse/dependence).

By way of illustration, in 2006 most of the clients who obtained help in outpatient treatment centres (55%) are reported to have an alcohol-use disorder (alcohol use or harmful use according to ICD-10 criteria), whereas disorders related to other substance use were treated as follows: opiates 21%, cannabis 13%, cocaine and stimulants 3% each. A total rate of approximately 3% corresponds to clients receiving treatment for eating disorders and pathological gambling (Sonntag et al., 2007a). As regards the inpatient centres, the situation is as follows: the proportion of clients who were treated for alcohol use disorders in 2006 amounts to 74%, whereas opiate use disorders correspond to 9%, cannabis use disorders to 4%, cocaine and stimulants to approximately 1% each. The percentage of clients with a primary diagnosis of pathological gambling was 1.1% (Sonntag et al., 2007b). As regards the inpatient institutions, it should be mentioned that a distinction is more frequently and typically made between those institutions which mainly treat patients with alcohol-use disorders and those addressing mainly clients suffering from disorders resulting from illicit drug use.

5.3.6 Availability/link to somatic and psychiatric treatment

Health aspects of drug use are addressed by specific treatment provision for drug users as well as within the framework of general health care. Outpatient services facilitate access to basic medical care which is generally provided by office-based doctors in their function as medical consultants. Dental treatments which have been put off for a long time and other medical treatments are common and are done during inpatient addiction therapy. In a few *Länder*, specific projects on dental hygiene and infection prophylaxis are offered as part of low-threshold drug aid.

In view of the high infection risks for hepatitis A and B, vaccination programmes for injecting drug users are an important instrument of infection prophylaxis. They are applied in many settings.

Furthermore, during the phase of detoxification an overall assessment of the health condition of the drug users is provided, which results either in the immediate provision of the care requested or in referral to the appropriate health service.

Information on the availability/link to psychiatric treatment can be found in the section above on "Dual diagnosis treatment".

5.3.7 Rehabilitation services linked to treatment

Housing

There is a range of opportunities available for drug addicts to tide them over homelessness. Statistical material on this is contained, for example, in the *Länder* short reports (last reference year: 2004). In 45 low threshold facilities over 630 emergency beds are provided specifically for this target group. Approximately 300 facilities offer assisted living for about 7 600 people. The transition from inpatient therapy to a fully self-sufficient life is to be facilitated by adaptation facilities. Of these, 81 are spread countrywide offering transitional support to 983 clients (Simon, 2005).

Education and training

In the last few years, a series of measures to improve the integration of jobless people with disabilities into the labour market has been tested. Generally, these measures have not been specifically developed for people with substance-related problems, but they are commonly found among the target group enlisting for these activities. Parts of the test results have been taken into account in the revision of the Social Codes II, III and XII.

Many facilities complement therapy by offering promotional programmes for drug addicts to support educational attainment and vocational training or to provide orientation for their professional life. Drug addicts are also given the opportunity to catch up on missing school leaving certificates within the framework of external school projects. Vocational training is made possible through close co-operation between craft and industry. However, in view of the high unemployment rates and the rather declining financial resources allotted to this area, a fundamental improvement of the situation is required.

Employment

The tense situation on the labour market makes it even more difficult for substance dependent people to reintegrate into professional and social life. Nonetheless, countrywide, there were approximately 50 work projects or

qualification measures with approximately 700 places specifically available for drug addicts in 2004. A total of about 1 800 places in 124 facilities were offered to people with substance-related problems (Simon, 2005). Within the framework of the content-related and structural further development of existing rehabilitation provision, the targeted promotion of employment opportunities of jobless addicts in rehabilitation therapy by the Federal German Pension Insurance (Deutsche Rentenversicherung Bund)[9] at national level has become an integral part of the therapy for people with addiction-related illnesses. It comprises, for example, indicative groups with regard to unemployment and training for job applications. From the viewpoint of the social security administration, the central goal of addiction therapy is the restoration of the capacity to work. Apart from somatic aspects also psychological factors – that is, the personal and social competences of the client – are taken into account to prepare clients for work (Pfeiffer-Gerschel et al., 2007).

5.3.8 Treatment of young people

There are relatively few specialised facilities offering counselling and care for children and teenagers with drug problems. Specifically, the extent of drug use among children and teenagers aged below 15 years of age is rather small in Germany, but apparently growing in some areas as reflected by the demand for therapy. For example, in 2005, 10 times more children and teenagers underwent outpatient therapy than in 1996. Therapeutic offers for this age-group are rare (Simon et al., 2006).

In Germany, drug use in younger age-groups can nearly be equalled to cannabis use and partly to the use of amphetamine (and other stimulants). According to recent data (2006), the mean age of first use of cannabis among the people who started therapy in an outpatient addiction facility is 15.6 years, whereas the age of first use of opiates and cocaine is 20.1 and of amphetamine is 17.9 years. In addition, the available data suggest that cannabis clients in outpatient centres tend to be relatively young: the mean age of starting treatment is 23.6 years, whereas patients with other primary drug dependencies tend to enter treatment at a much older age (for amphetamine the mean age is 25.3 years, for cocaine it is 31.1 years and for opiates 32.3 years) (Sonntag et al., 2007c).

Consequently, it could be stated that the following programmes tailored specifically to cannabis users address and attract mainly young people:

9. BfA (Bundesversicherungsanstalt – National Pension Insurance for Salaried Employees) and LVAs (Landesversicherungsanstalten – Land Pension Insurances for Wage Earners) were merged to form the Deutsche Rentenversicherung Bund (Federal German Pension Insurance) as of 1 October 2005.

– The gap between prevention and therapy in the area of problem cannabis use is getting smaller. Over the last few years, traditional drug counselling facilities have increasingly been used by cannabis users also. However, there has been no scientific, evaluated therapy concept for this target group yet. A step in this direction was taken by the international multi-central study "INCANT" (International Cannabis Need of Treatment Study) to improve therapy for cannabis users. The main phase of the study started in early 2007. The University of Dresden has developed a treatment programme for cannabis-use disorders and results have recently been published (CANDIS). It is planned, to implement CANDIS in selected outpatient treatment centres in 2008.
– The goal of the German-Swiss project "Realize it" aims to significantly change the consumption behaviour of the participating 15-30-year-old cannabis users. The programme on short intervention in cannabis use is to be tested in the course of the project, evaluated and afterwards systematically integrated into the spectrum of treatment offered by drug counselling facilities in Germany and Switzerland.
– A similar project is the Internet-based programme "Quit the shit" offering support to stop using cannabis. The Bundeszentrale für gesundheitliche Aufklärung (BZgA – Federal Centre for Health Education) has asked 12 drug counselling facilities in Germany to use the Internet-based programme and take over the counselling of the clients.

Beside numerous activities addressed to children and teenagers who have drug problems, the following should be also mentioned by way of example:

– "Stop over", an abstinence-oriented clarification and motivation programme for young drug users or teenagers who are at risk of developing addiction, is located in Berlin.
– A facility in Hanover combining inpatient and outpatient measures comprises important elements from both addiction therapy and youth welfare and is funded by the child and youth welfare system. Care is provided by the same person over the longest possible period of time, which is of major importance for this age-group (Schoor and Möller, 2005).

5.4 Gender issues

Treatment of drug users and addicts is becoming increasingly affected by gender-related aspects. Originally, the German addiction assistance system started with a clear over-representation of men. Only gradually have concepts developed on the basis of a gender-specific approach taking into account gender-specific differences between drug-using women and men. This applies both to out- and inpatient treatment, aftercare and the self-help system. Zenker et al. (2005) note that, due to the gender distribution

among clients, the help system is implicitly oriented towards male addicts and barely addresses the demands and needs of female addicts in counselling and therapy. However, nowadays, accounting for gender issues is an integral part of professional drug counselling and treatment in Germany. Over and above that, several specialised facilities do exist, offering assistance to women addicts.

In order to make it possible for drug using women with a child to undertake withdrawal treatment, inpatient facilities have started to offer common accommodation for both mother and child. More than 25 facilities provide such mother-child opportunities. Many outpatient facilities have meanwhile reacted to the needs of addicted mothers providing child care during therapy sessions.

Since the beginning of the 1990s, facilities have been opened to cater for drug-using prostitutes. The services provided range from different types of survival training to counselling. Comparable facilities catering for drug-using male prostitutes do not exist (Simon et al., 2005).

5.5 Treatment within the criminal system

Substitution therapy conducted in prison is subject to very different regional regulations. In general, the continuation of substitution therapy which started before the beginning of a prison sentence is possible in all *Länder*. The same applies to the use of methadone in withdrawal treatment. Whether substitution therapy can be started in prison depends on the *Land* regulations and the prison doctor's decision. The possibility of undergoing substitution therapy in prison is only offered region-wide in a few *Länder*. Programmes are generally limited to three-six months (Pollähne and Stöver, 2005). In 2006, the total number of those convicted for violations of the Narcotics Act was 9 579. This corresponds to 14.8% of the overall prison population. However, comprehensive data on the number of imprisoned drug users as well as on the percentage of them receiving treatment in prisons are not available at the moment.

A survey commissioned by the working group "German Statistics on Addiction Treatment" (Arbeitsgruppe Suchthilfestatistik, AG DSHS), carried out by the German Reference Centre for the EMCDDA (DBDD) at the ministries of justice of the *Länder* in the year 2005, gives a broad overview of the current situation. In six out of 10 *Länder* for which detailed information was available, the clients were attended to by external consultants. These generally come from outpatient private charity counselling facilities. In many *Länder*, internal and external consultants are used.

Substitution therapy – as far as it is available – is primarily accompanied by internal medical prison staff (Simon and Tischer, 2006). The main areas of addiction work in prisons are prevention, motivation to undergo

rehabilitation treatment, referral to inpatient withdrawal facilities or aftercare.

6 Special issues

6.1 Institutions and organisations

A differentiation between drug-free and pharmacologically assisted treatment is not very useful to describe the therapy system in Germany. Whereas a large part of the activities undertaken by general practitioners can be assigned to medication assisted therapy, services offered by psychosocial counselling facilities which represent a central element of care, can only be clearly assigned in those cases in which they themselves supply the substitution drugs. In many cases, however, medical substitution takes place outside the counselling facilities. In this way, psychosocial care or therapy provided by the counselling facilities is, per se, neither a prerequisite to a drug-free nor a medication-assisted approach.

Parallel to and partly in co-operation with offers of professional help, there are a host of self-help organisations active in the field of addiction. So far, however, their activities have been mainly geared to alcohol addicts and older target groups.

6.2 Treatment demand and evaluation

Planning of the treatment demand in the different segments of the medical and/or social help system at national level is not compatible with the federal structure of Germany. Instead, planning is done at *Land* and municipal level; for example in Hesse, like in many other parts of Germany, co-operation between addiction support and youth welfare is currently intensified with a view to specifically catering for the needs of younger drug users. To this purpose, integrated youth and addiction support centres were created (Hessisches Sozialministerium, 2006).

So far, substance-related disorders of those aged over 60 have not received much attention. However, with the changing population structure, higher life expectancy and changed use patterns beyond the age of 60 marks this issue as one that needs attending to.

Apart from this group of addicts of licit substances, the number of ageing opiate users in and outside substitution is also growing. Here, the help system is faced with new challenges. For this target group there are hardly any places available in therapy which would be adequate in terms of therapy goals, therapy setting and insurance conditions.

6.3 Heroin trial

Following the preparatory works of the years 2000 and 2001, the "Demonstration project on diamorphine-assisted therapy of opiate addicts" started in 2003 and final results were published in 2006 (Naber and Haasen, 2006).

Despite the positive results of the so-called "heroin trial", it is still uncertain whether treatment with diamorphine will be continued in Germany. In 2006, an application for the admission of diamorphine as a prescription drug was filed with the Federal Institute for Pharmaceutics and Medical Devices (Bundesinstitut für Arzneimittel und Medizinprodukte – BfArM). Although the BfArM has meanwhile given its technical endorsement, the drug cannot yet be authorised because the Narcotics Act, which, in its present wording, prohibits the prescription of diamorphine, needs to be changed accordingly (Pfeiffer-Gerschel et al., 2007). Based on a special regulation, the study has been prolonged until June 2007. Since then, responsibility for financing of each of the study sites has been handed back to the participating municipalities. Prolongation of the project was thus only deemed appropriate if sufficient "public interest" was expressed in each of the participating communities.

7 Strengths and weaknesses

Nowadays, the German treatment system for individuals suffering from drug-related problems can be seen as a comprehensive, professionally driven and complex one. Generally, professional help can be provided at each stage of the development of an individual's drug career and many interfaces do exist between different treatment methods (such as in-/outpatient, social treatment or medically assisted treatment). Usually, treatment of drug-related problems in specialised treatment centres attempts to take into account as many aspects of the individual's problems as possible, resulting in comprehensive provision to enable clients to get back into working life or to stabilise or even improve physical conditions. As drug users are a heterogeneous group and correspondingly individual needs differ among the population, specialised treatment opportunities (such as mother-child treatment or programmes addressing users of a certain drug) have been developed and implemented. These different needs are also reflected in a systematic treatment approach that defines different stages of the treatment process resulting in provision of different treatment ranging from harm-reduction measures to a possible long-lasting substitution treatment in the case of severe opiate addicts. Generally speaking, barriers to access to treatment for drug users are not very high, but, depending on the nature of the respective treatment on offer, thresholds may be higher for individual programmes. For example, access to detoxification as a first step in the treatment chain is usually pretty easy, whereas long-lasting inpatient treatment

usually requires commitment from the patient, a funding institution (e.g. health insurance or pension funds) and the treatment provider.

A broad variety of treatments do exist and are continuously complemented by the results of additional drug-related research and the further development of guidelines and treatment standards. Due to a long tradition in treatment documentation, developments can be followed over long periods. Quality assurance became a matter of interest several years ago and meanwhile many treatment guidelines do exist and have been systematically evaluated and implemented in the field.

With respect to weaknesses, the systematic provision of drug-specific treatment including substitution treatment in prison is certainly an issue worth mentioning. As this area also falls under the responsibility of the federal *Länder*, considerable differences do exist, as to how treatment for drug addicts is implemented. No reliable national figures exist on the extent of the drug problem in German prisons, bearing in mind that the number of individuals convicted for violations of the Narcotics Act does not reflect the number of imprisoned drug users and no systematic overview is available on how drug-specific treatment is implemented in the individual *Länder*. Over and above that, existing regulations are not necessarily identical, resulting in an overall situation where the provision of treatment or even harm-reduction activities differs from one prison to another.

Due to the complexity of the treatment system and the variety of involved institutions in the field, co-ordination and communication between different funding institutions and treatment providers could be improved in some cases. Over and above that, certain treatments, such as, for example, treatment for dual diagnosis (psychiatric disease and drug dependence) should be expanded in the future. Transition between different treatment methods or the ending of treatment still remain high-risk periods for individual clients and further efforts will be made to improve this situation.

Currently, research is increasingly interested in understanding the basic mechanisms of drug dependence and the complex interaction between biological and social aspects which facilitate the development of a drug use disorder in a given individual. Results of this research will help to better allocate patients according to their individual needs with the best treatment available.

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www.dhs.de – German Centre for Addiction Issues – Deutsche Hauptstelle für Suchtfragen (DHS)
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Ireland

1 Demography

Population levels in Ireland are at their highest since 1861. The 2006 census indicates a population of 4.24 million which represents an increase of 16.8% since 1996. Net immigration is estimated to have accounted for the vast bulk of this increase. Nearly 420 000 (10%) people who were usual residents of the state in April 2006 indicated that they had a nationality other than Irish. Approximately 35% of the population overall is aged 24 years or under and 11% is aged 65 or over. Ireland occupies an area of just over 7 million hectares.

2 Epidemiology of drugs use

Results from a 2006/2007 population survey show that in Ireland:

– almost one in four people (24%) had used an illegal drug at some point in their lives;
– one in fourteen (7%) had used an illegal drug in the past year; and
– one in 30 (3%) had used an illegal drug in the past month.

Cannabis was the most commonly used illegal drug with 22% of the adult population having ever used the drug; 6% reported using cannabis in the year prior to the survey and 3% reported current use. Lifetime prevalence of all other illegal drugs was considerably lower than cannabis. For example, 6% reported using magic mushrooms at some time, followed by ecstasy and cocaine (each 5%), amphetamine (4%), poppers and LSD (each 3%), while the use of solvents was reported by 2% of the adult population and less than 1% reported use of crack (0.6%) and heroin (0.4%).

The lifetime prevalence rate for any illegal drugs was highest among those aged 25-34 years (34%) followed by those aged 15-24 years (28%) and those aged 35-44 years (27%). A higher proportion of men than women continue to report lifetime, past year and past month use of any illegal drugs. Women and older adults continue to report higher levels of use of sedatives and tranquillisers. A similar pattern was found for antidepressants.

In relation to cocaine, 5% of those surveyed in Ireland had used cocaine at least once in their lifetime. This was a significant increase from 2% in the previous survey in 2002/2003. Less than 1% (0.5%) had used cocaine in the past month but this rose to 1% among younger people aged 15-34.

There are an estimated 14 500 opiate users in Ireland based on a capture-recapture study carried out in 2002. The National Advisory Committee on

Drugs is proposing to repeat this study in 2008. There were a total of 8 537 patients on the Central Treatment List for methadone substitution at the end of 31 December 2007.

The 3rd Irish Health Behaviour in School Children Survey (HBSC) 2006 among 10-18 year-olds shows that cannabis use remains relatively stable across most age-groups, although there has been a decrease between 2002 and 2006 in reported use of cannabis in the last 12 months among 15-17-year-old boys. Overall, 12% reported using cannabis in the last 12 months in 2006 compared to 11% in 2002 with little evidence of a social class effect. Cannabis use was highest in the 15-17 age-group with about one in five in this age-group using cannabis in the previous 12 months. More boys (8%) than girls (5%) report using cannabis in the last 30 days. A social class effect is clearly evident among 15-17-year-old boys who report more recent cannabis consumption (last 30 days); 10% of boys in the highest social class reported cannabis use in this time frame compared to 15% in the lowest social class.

Data from the National Drug Treatment Reporting System (NDTRS – an epidemiological data base of those treated for drug misuse) for 2006 shows that the main problem drugs among those entering treatment were opiates (65%), cannabis (20%) and cocaine (10.6%).

An exploratory study of drug use among Travellers (an indigenous ethnic minority group) found that their drug use mirrors that in the general population.

2.1 Mortality

The General Mortality Register, the main source of information on drug-related deaths prior to the establishment of the National Drug-Related Deaths Index (NDRDI) in 2005, shows that the number of direct drug-related deaths climbed steeply from a low base in the mid- to late 1990s reaching 122 in 1999, decreasing to 113 in 2000, 93 in 2001, 90 in 2002, 96 in 2003 and 112 in 2004 – the latest year for which data are available. Direct drug-related deaths refer to those due to intentional or unintentional overdose. Of the direct drug-related deaths between 2001 and 2004, 60% were as a result of opiate overdose. These figures do not include deaths which are indirectly related to drug use. The NDRDI was established in September 2005 to provide more comprehensive information on drug-related deaths. The first NDRDI publication is scheduled for autumn 2008.

2.2 HIV/hepatitis

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. By the end of 2006, there were 4 419 diagnosed HIV cases in Ireland, of which 1 327 (30%) were probably infected through injecting drug

use (Health Protection Surveillance Centre, 2007). The most recent studies indicate that one in 10 injecting drug users are infected with HIV.

A total of 337 newly diagnosed HIV infections were reported to the Health Protection Surveillance Centre during 2006, a 6% increase on the 2005 figure. Almost 17% of these 337 were among injecting drug users. Although the incidence of HIV is increasing, newly diagnosed HIV infection rates have fallen somewhat in recent years with an estimated rate of 7.95 per 100 000 population in 2006 compared to 10.03 per 100 000 population reported in 2003.

There is no figure available on the prevalence of hepatitis C in the general population. In 2006, 1 226 cases were notified compared to 1 434 in 2005. Prevalence estimates of hepatitis C among injecting drug users attending community-based drug services range from 54% to 84% (1995 study). Estimates for prison inmates and entrants are 81% and 72% respectively. Approximately seven in every 10 injecting drug users attending drug treatment test positive for antibodies to the hepatitis C virus (Long, 2006). Enhanced fields were added to the surveillance system in February 2007 to capture data on routes of transmission.

There were 820 cases of hepatitis B reported in 2006. About one in five injecting drug users in treatment have at some time been infected with hepatitis B. Approximately 2% are chronic (as opposed to acute) cases. TB among injecting drug users in Ireland is not currently a major problem.

3 Short history of drug treatment

Treatment services are provided within the framework of the National Drugs Strategy. The overall strategic objective for the National Drugs Strategy 2001-2008 is to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on the four pillars of supply reduction, prevention, treatment and research. A fifth pillar, rehabilitation, has recently been added to the strategy to give more emphasis to social reintegration. A partnership approach between statutory, voluntary and community sectors in addressing drug issues, including treatment, is an important dimension of the National Drugs Strategy.

The objectives of the National Drugs Strategy in relation to treatment are:

– to encourage and enable those dependent on drugs to avail themselves of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug-free lifestyle; and

– to minimise the harm to those who continue to engage in drug-taking activities that put them at risk.

For historical reasons arising in the 1980s and 1990s the focus of concern around drug issues has been on opiates, particularly heroin, with methadone substitution the dominant mode of treatment supported by some psychosocial approaches. More recently, however, the statutory provider, the Health Service Executive (HSE), as well as voluntary and community providers, have been re-orienting treatment services to tackle poly-drug usage (including alcohol and cocaine).

Two broad philosophies underlie the approaches to treatment: medication-free therapy and medication-assisted treatment. There is a small degree of overlap between the two. Medication-free therapy uses models such as therapeutic communities and the Minnesota Model, though some services have adapted these models to suit their particular clients' needs. Medication-assisted treatment includes opiate detoxification and substitution therapies, alcohol and benzodiazepine detoxification, and psychiatric treatment. Various types of counselling are provided through both philosophies of treatment and independent of either type of treatment. Alternative therapies, such as acupuncture, are provided through some community projects in Dublin.

The HSE Addiction Service supports the provision of an integrated range of preventative and therapeutic services to meet the diverse health and social care needs of their service users. The addiction services seek to deliver these services in partnership with local communities and private service providers where appropriate. In keeping with the treatment objectives of the National Drugs Strategy a comprehensive range of treatment services is provided including: substitution treatment; psychosocial therapies, for example cognitive-behavioural therapy and coping skills; and harm-reduction services such as needle and syringe exchange. Rehabilitation services are also provided, with a range of options including residential and day programmes and a planning and brokerage service designed to equip drug users with the skills and tools for progression and reintegration.

Services provided by a range of voluntary and community sector organisations include: drop-in services, peer support services, family support, education services, counselling services, rehabilitation and aftercare services, HIV/Aids support, training services and personal development training and complementary therapies. These are funded in a variety of ways: mainly by government funding (by the HSE and the Department of Community Rural and Gaeltacht Affairs) and some through voluntary fund-raising efforts and by health insurance.

The Report of the Working Group on Drugs Rehabilitation was published in 2007 (see www.pobail.ie) to strengthen and build on existing rehabilitation efforts. The report puts an emphasis on a client-centred approach, a continuum of care, case management and the development of protocols,

standards and service level agreements between agencies to facilitate progression routes. Drug rehabilitation in an Irish policy context is viewed as encompassing interventions aimed at stopping, stabilising and/or reducing the harm associated with a person's drug use as well as addressing a person's broader health and social needs (these needs may include health, social, housing, employment, educational and/or vocational).

Services aim to provide treatment to those who seek treatment for their drug use without distinction as to whether the drug is illicit or otherwise. The pattern of poly-drug use means that many clients are presenting to services with use of a combination of legal and illegal drugs, for example cocaine and alcohol, or heroin, alcohol and benzodiazepines (the latter are legal on prescription). Outreach services are also provided in an attempt to engage those with serious problems who may not be in contact with services.

4 Organisation of treatment services

In Ireland, under the Health Act 2004, the management and delivery of health and personal social services is the responsibility of the HSE. The HSE therefore has statutory responsibility for the provision of drug treatment services, including harm-reduction interventions. The HSE discharges this responsibility in conjunction, where appropriate, with the voluntary/community sectors. The Department of Health and Children has a policy remit in relation to drug treatment services and some aspects of prevention services.

From a legislative point of view the Department of Health and Children is responsible for the scheduling of substances and for treatment in general while the Department of Justice, Equality and Law Reform is responsible for enforcement and for drugs issues in prisons, including treatment. The main legislative instrument which affects provision of treatment is the Methadone Treatment Protocol which was introduced in 1998 under the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1988 (see section on substitution treatment below).

Treatment is provided through a network of statutory and non-statutory agencies. The HSE is the primary provider and driver of treatment services for problematic drug misuse and carries very significant responsibility in providing a range of addiction services incorporating education and prevention, harm reduction, treatment, stabilisation, rehabilitation and aftercare support to those affected by addiction. The HSE Addiction Service is a consultant delivered service (consultants in addiction psychiatry). There are in excess of 247 general practitioners and 427 pharmacists contracted by the HSE in the provision of treatment and dispensing under the methadone treatment scheme. General practitioners participating in the methadone treatment scheme have to undergo training at Level I or Level 2 depending on the number and complexity of the clients to whom they will provide care.

In addition there are approximately 730 employees including psychiatrists, nurses, outreach workers, counsellors/therapists, community welfare officers, psychologists, project workers, administrative staff, education officers and general assistants who are employed directly in delivering the HSE's addiction services. To meet changing patterns of drug use the HSE has been up-skilling its staff and is currently rolling out a National Addiction Training programme.

The HSE, as a core part of its organisation-wide transformation programme, is putting in place, on a phased basis, multidisciplinary primary care teams and social care networks. These are underpinned by a lifecycle approach which places the individual at the centre of policy development and service delivery by assessing the risks that face them and the support available/required at key stages of the lifecycle. This programme is particularly relevant to clients with social inclusion issues (including addiction) and the HSE is working towards embedding an integrated addiction (including alcohol misuse) service in this setting. The five key priorities for clients including clients of the addiction service are: improved access; training and quality standards; continuity of care; community involvement and participation; and intersectoral collaboration.

Voluntary agencies also provide drug treatment services both outpatient and residential and some also organise staff training courses.

Treatment services are also provided under action plans developed by local and regional drugs task forces. The 14 local drugs task forces (LDTFs) were established in the late 1980s in response to opiate problems in urban areas of economic and social disadvantage. More recently the LDTF model was expanded to cover the entire country through 10 regional drugs task forces (RDTFs). The drugs task forces bring together the statutory, voluntary and community sectors at local and regional levels to address drug issues in a co-ordinated way. Drugs task forces are charged with developing action plans for their areas to address the gaps in service provision. The work of the drugs task forces is overseen by a National Drug Strategy Team (NDST) which consists of representatives of relevant government departments and agencies, as well as the voluntary and community sectors. Proposals put forward by the drugs task forces are assessed by the NDST which makes recommendations for funding to the Department of Community Rural and Gaeltacht Affairs which has the overall co-ordination remit for the National Drug Strategy.

5 Services

5.1 Detoxification

Detoxification from illicit drugs is provided in medical residential detoxification units and in community-based detoxification programmes with residential support.

Medical residential detoxification units are aimed at individuals presenting with a high level of need, complex patterns of problem drug use and associated physiological problems (e.g. hepatitis C). They involve inpatient drug/alcohol detoxification or stabilisation services. These services are under the direction of a medical director/consultant psychiatrist with specialist skills in the area of substance misuse and involve multidisciplinary teams covering psychiatry, a general practitioner, nursing and counselling/therapy. Twenty-three beds are provided under this category by the statutory sector. The Report of the Working Group on Drugs Rehabilitation published in May 2007 found that there was an urgent need to increase the number of detoxification beds available in Ireland and as an interim measure recommended an additional 25 detoxification beds.

Community-based detoxification programmes with residential support are aimed at problem drug users who have been assessed by a general practitioner as appropriate for community-based detoxification but who require a high level of support, in terms of their environmental/psychosocial needs, in a residential setting. Clients in this category usually have less intense medical needs that do not require inpatient medical care. Providers offer significant psychosocial/therapeutic support and/or skills-based training to those in treatment. There is a close liaison between the provider and the designated community-based general practitioner in relation to the detoxification element of care plans. Seven community-based residential detoxification beds for methadone detoxification are provided by the voluntary sector.

The Report of the Health Service Executive Working Group on Residential Treatment and Rehabilitation (Substance Users) published in early 2008 recognises the poor geographic distribution of detoxification services. There are no dedicated residential stabilisation or detoxification beds (either residential community-based or hospital-based) outside of the Dublin area. Detoxification of drug users also takes place in psychiatric hospitals and units throughout the regions. The report recommends that "where inpatient detoxification is required, it should be as a rule provided in dedicated units. The use of general hospital or psychiatric beds for detoxification should be the exception since the evidence base indicates better outcomes from specialist units". In order to achieve a ratio of 15 detoxification beds per half million total population, the report identified the need for a further 79 detoxification beds additional to the 25 recommended on an interim basis in the rehabilitation report. Since the HSE is currently reorienting its service towards an integrated addiction service addressing all substance misuse, including alcohol misuse, the report recommended that the additional 104 beds be allocated on a 40:60 ratio between drugs and alcohol.

5.2 Evaluation/planning of treatment

The National Advisory Committee on Drugs (NACD: www.nacd.ie) has undertaken or commissioned a number of studies on treatment-related

issues including outcomes. The Research Outcome Study in Ireland evaluating drug treatment effectiveness (ROSIE) is the first national, prospective, longitudinal, multi-site drug treatment outcome study undertaken in Ireland. The NACD commissioned this study in 2002 as required by the National Drugs Strategy Action 99. The aim of the study was to recruit and follow opiate users entering treatment over a period of time documenting the changes observed. The study recruited 404 opiate users entering treatment; 20% of the study population or 82 participants were commencing treatment in abstinence-based programmes.

At one-year follow-up the study found marked reductions in drug use and criminal activity among study participants. In addition, a low mortality rate was observed. Although no significant changes were observed in injecting-related risk behaviour or overdose, the rates were low at treatment intake. Some positive outcomes were observed for participants' physical and mental health complaints, despite the relatively short time period. These findings suggest that involvement in drug treatment has a positive impact on individuals.

The HSE drug treatment services is a consultant service led, and in some cases provided, by consultants in addiction psychiatry. In relation to treatment planning in general, the practice is that patients are assessed and a decision made on the most appropriate treatment. One of the national performance indicators for the statutory addiction services is that treatment as deemed appropriate should commence within one month of assessment. The Methadone Prescribing Implementation Committee (MPIC) monitors implementation of the Methadone Treatment Protocol and meets on a quarterly basis. The introduction of a Regulatory Framework for Buprenorphine and Buprenorphine/Naloxone and a feasibility study in a number of specialist and community sites are currently under consideration by an expert group which is due to report to the Minister for Health and Children in early 2008.

5.3 Treatment

5.3.1 Substitution treatment

Methadone substitution treatment is provided for opiate users in accordance with the Methadone Treatment Protocol (there are an estimated 14 500 opiate users in Ireland). The Methadone Treatment Protocol was introduced in 1998 under the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1988. Under the protocol, treatment for opiate users should be provided in the misusers' own local area wherever possible. Locally based methadone treatment for opiate misusers is provided through drug treatment clinics, through satellite clinics or through specially trained general practitioners in the community. The involvement of community

pharmacists in the dispensing of methadone allows for a large number of opiate dependent persons to be treated in their own local area.

Under the regulations a Central Treatment List was established. This list is commissioned by the HSE and compiled by the Drug Treatment Centre Board (DTCB). A drug treatment card is issued by Central Treatment List personnel in respect of patients notified to it by doctors. These drug treatment cards relate to an individual patient and will specify a named doctor and a named pharmacy. The drug treatment card is held by the pharmacy on behalf of the patient. The MPIC monitors implementation of the Methadone Treatment Protocol and meets on a quarterly basis.

As at 31 December 2007, a total of 8 537 client placements were recorded on the Central Treatment List as being on a methadone treatment programme. Almost 5 000 (4 976) of these had their methadone dispensed by pharmacists in community settings rather than in specialist addiction clinics. There are 247 general practitioners and 427 pharmacists involved in the delivery of services under the methadone protocol.

Drug users with more complex issues are treated at a specialist clinic in the DTCB Trinity Court in Dublin and those who achieve stabilisation on methadone there are usually then released to the more local services.

There is a continuing high level of demand for treatment for opiate dependency in the HSE eastern regional area (Greater Dublin area) and use has also spread further afield. The HSE is working closely with the DTCB to increase the numbers in treatment and reduce waiting lists and times for accessing treatment. In the HSE eastern regional area there are currently 59 drug treatment locations. These are a mix of larger addiction centres and satellite clinics. This is an increase of 47 locations since 1996. Drug misusers attending the larger addiction centres and the satellite clinics are all registered on the Central Treatment List. Outside the eastern regional area, seven treatment clinics have been established; in the south-east, mid-west, west and midland area.

5.3.2 Drug-free treatment services

Abstinence-based residential rehabilitation programmes cater for clients who are drug- and alcohol-free. The programmes are abstinence-oriented and the emphasis is on understanding and maintaining a drug- or substance-free lifestyle. In Ireland the ethos underlying the programmes varies in orientation, ranging from the 12-step model to the therapeutic community approach to the systemic/psychotherapeutic model. All services are therapeutic by nature and, to varying degrees, emphasise skills enhancement, vocational skills training and personal responsibility. Most programmes are connected with the statutory HSE addiction service treatment providers in terms of treatment support/consultation. A total of 546 beds are provided

under these programmes, of which 363 can cater for problem drug users, though the number occupied by problem drug users at a given time varies and can be quite small (most of the remainder being for patients with alcohol problems). Many of these service providers, who are predominantly from the voluntary sector, provide community-based day services as well. They also offer aftercare and reintegration programmes after completion of the residential programmes.

The Research Outcome Study in Ireland evaluating drug treatment effectiveness (ROSIE) recruited and followed 404 opiate users entering treatment (or needle exchange) to document their progress after six months, one year and three years. *Findings 3* from the study provides a summary of the outcomes for the 82 people in the abstinence modality one year after treatment intake (Cox et al., 2007b, www.nacd.ie). The authors state that *Findings 3* demonstrates that participation in an abstinence-based treatment programme is followed by positive outcomes in relation to drug use, involvement in crime, and physical and mental health symptoms. The outcomes for ROSIE participants in abstinence-based treatment compare favourably with international outcome studies. As noted in the paper, the forthcoming results from the ROSIE three-year follow-up will provide stronger evidence on the effectiveness of abstinence-based treatment programmes and on whether improvements observed at one year have been sustained.

5.3.3 Dual diagnosis treatment

The issue of dual diagnosis has provided challenges to the treatment services in Ireland. A study undertaken by the National Advisory Committee on Drugs in 2004 found gaps in policy and practice in relation to the management of dually diagnosed people among service providers in both the mental health and addiction fields. *A vision for change – The report of the Expert Group on Mental Health Policy* published in 2006 and currently being implemented on a phased basis, addressed the issue of dual diagnosis (people with co-morbid substance abuse and mental health problems). This report states that the major responsibility for care of people with addiction lies outside the mental health system. Mental health services for both adults and children are responsible for providing a mental health service only to those individuals who have co-morbid substance abuse and mental health problems. General Adult Community Mental Health Teams (CMHTs) should generally cater for adults who meet these criteria, particularly when the primary problem is a mental health problem. The report also recommended that a specialist adult team be established in each catchment area of 300 000 population, to manage complex, severe substance abuse and mental disorder. These specialist teams should establish clear linkages with local community mental health services and clarify pathways in and out of their services to service users and referring adult CMHTs.

The HSE is currently implementing an organisation wide Transformation Programme towards a more client-centred continuum-of-care type service. This programme includes the roll-out on a phased basis of primary care teams and social care networks with a focus on integrated care pathways. It is proposed that the embedding of an integrated addiction services in this setting, which the HSE is currently undertaking, provides an opportunity to create the kind of service linkages which will better address the existence of psychiatric co-morbidity in substance misusers.

5.3.4 In/outpatient

Ireland has a National Drug Treatment Reporting System (NDTRS) which is an epidemiological database on treated problem drug and alcohol use. The NDTRS is co-ordinated by staff at the Alcohol and Drug Research Unit of the Health Research Board on behalf of the Department of Health and Children. For the purpose of the NDTRS, treatment is broadly defined as "any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems". The data presented below were collected through outpatient (opiate detoxification, methadone substitution and counselling services), inpatient (medical detoxification and medication-free residential programmes) and low-threshold centres (low-dose methadone and crisis-counselling services).

Outpatient services

In 2006, there were 146 services providing outpatient services and reporting cases to the NDTRS. Of these services, 55 provided methadone treatment, a small number provided detoxification using lofexidine, and one provided buprenorphine detoxification. All provided counselling services and a large proportion provided brief interventions.

In addition, as already mentioned in Section 4 above, there are in excess of 247 general practitioners and 427 pharmacists contracted by the HSE in the provision of methadone substitution treatment and dispensing.

Inpatient services

There were 23 inpatient services reporting cases to the NDTRS in 2006. These facilities provided one of the following: medical detoxification, therapeutic community, Minnesota Model, other medication-free service or psychiatric treatment combined with counselling.

Low-threshold services

In 2006, there were three services providing solely low-threshold services and reporting cases to the NDTRS. The three services were based in the north and south-western areas of Dublin. Of these services, two provided

low-threshold methadone maintenance and one provided crisis counselling. For many of the community services, it is difficult to separate low-threshold activities from treatment interventions and services. Both crisis interventions and counselling services have been and continue to be classified as outpatient treatment services.

5.3.5 Drug and/or alcohol and prescribed drugs

The EMCDDA report (2006) on selected issues states that "in Ireland treatment services for drug use and alcohol use are not officially linked, although in practice many drug services also treat clients with alcohol dependence. The reason for this is that one fifth of those treated for problem alcohol use also misuse drugs". Likewise 22% of all treated drug users recorded by the NDTRS in 2004 and 2005 reported additional problem alcohol use and 33% of new cases treated reported problem alcohol use. The statutory service treatment of under-18 year-olds with alcohol problems is delivered within the drug services. The National Drug Strategy includes alcohol issues for under-18 year-olds and for adults where this is required for a holistic approach to clients in the context of poly-drug use. This empowers projects funded through local and regional drug task forces to address both issues within those limits. While some counsellors will only counsel for either alcohol or drug problems, increasingly counsellors will do both.

About two thirds of residential treatment/rehabilitation beds are available for treating people with either alcohol or drugs problems or both, suggesting considerable existing synergies in the residential treatment/rehabilitation area. The Report of the HSE Working Group on Residential Treatment/ Rehabilitation (Substance Users) identified in the region of 630 residential rehabilitation beds of which 31% are for alcohol only. However the HSE report qualifies this by stating that "[m]any rehabilitation services in theory deal with both drug and alcohol problems, but in practice a higher proportion of beds deal with alcohol-related problems".

Historically in the eastern region (the Greater Dublin area) where services for opiate users have been concentrated, alcohol treatment services have tended to be provided separately to drug services. In other regions there would have been stronger linkages between drug and alcohol services. The HSE is of the view that there should be a strong linkage between drug and alcohol treatment. This does not imply that all treatments for people with difficulties in all substances should be provided at the same locations. The detailed planning of the distribution of treatment locations needs to be worked on but the principle of linked treatment should apply.

Already the HSE is having to refocus its treatment strategies to include substances other than opiates and it views this as an ideal time to include alcohol in an integrated addiction (substance) service. The four-tier model

of care now being promoted by the HSE addiction services could accommodate alcohol.

This is also in accordance with the HSE programme for the phased development of primary care teams and social care networks which are striving to develop client-centred services for those with drug, alcohol and other care issues in an integrated fashion.

In relation to recruitment and training of staff for treatment interventions, HSE is of the view that it is sensible to include all substances in this brief as the theoretical models do not discriminate between legal and illicit drugs, and where people are recruited to provide treatment, they should have a brief to cover all substances. This does not mean that certain services could not be exclusively for one substance.

At national policy level a working group chaired by the Department of Health and Children is now examining the question of whether there should be a combined strategy for alcohol and drugs and how synergies between the two areas can be improved.

5.3.6 Availability/link to somatic and psychiatric treatment

In 2005, the Minister of State at the Department of Health and Children introduced a new statutory instrument known as the Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2005 (Statutory Instrument No. 510 of 2005). This permits the supply of a number of medicinal products (including naloxone for the management of respiratory depression secondary to a known or suspected narcotic overdose) to pre-hospital emergency care providers. This medication can be administered by advanced paramedics in accordance with clinical procedure guidelines or following a medical practitioner instruction. In addition, emergency technicians may administer naloxone in accordance with a medical practitioner instruction. This can improve the speed of response to narcotic overdoses.

In Ireland, HIV screening is conducted at drug treatment services and in the prison health service. The evidence suggests that take-up of these services is good. HIV treatment, a combination of highly active antiretroviral therapies, commonly referred to as HAART, is available to injecting drug users through genito-urinary medical units and infectious diseases clinics in Ireland.

Hepatitis B is a vaccine-preventable disease, and the current policy in Ireland is to target identifiable risk groups for vaccine (including injecting drug users, prisoners and homeless people). The vaccine (a series of three injections, with a booster) is available to all injecting drug users attending drug treatment.

In relation to hepatitis C, addiction services provide advice, information and routine screening for antibodies with follow-up polymerase chain reaction

(PCR) testing and referral to the acute hospital specialist hepatology services (of which there are seven in Ireland) when necessary.

The principles of expanded and accessible harm-reduction measures are documented in both the AIDS Strategy 2000 and the mid-term review of the National Drugs Strategy. Needle exchange services have expanded in recent years mainly in urban areas with the highest concentrations of opiate users. However it is recognised that there is a need to improve coverage of needle exchange throughout the country.

For links to psychiatric treatment see under Section 5.3.3 above.

5.3.7 Rehabilitation services linked to treatment

The report of the Working Group on Drugs Rehabilitation published in 2007 noted that services have been developed in each LDTF area (14 urban areas of socio-economic disadvantage), aimed at assisting recovering problem drug users to access opportunities relating to existing education, training and employment services. These latter services are catered for predominantly by mainstream providers such as the vocational education committees, FÁS (the national training agency), local employment services and area-based partnerships. One thousand FÁS community employment places (across 65 projects) are already ring-fenced for recovering drug users and, in the context of the report on drugs rehabilitation, the Department of Enterprise and Employment has agreed to increase this number by another 300. These places are considered a key element in the drugs rehabilitation effort.

With respect to young recovering problem drug users, initiatives such as Youthreach and VTOS (Vocational Training Opportunities Scheme) are available to those not immediately able to return to mainstream education for whatever reason. For adult recovering problem drug users, literacy and numeracy courses are often a key initial step on their educational pathway.

The report of the Working Group on Drugs Rehabilitation recommends a model of integrated service delivery which focuses on a client-centred continuum of care underpinned by case management, protocols for inter-agency working, service level agreements and additional detoxification beds. Key players in this new rehabilitation pillar under the National Drug Strategy are the HSE, the Department of Community Rural and Gaeltacht Affairs, FÁS, the Department of Education and Science and the regional and local drugs task forces. The treatment and rehabilitation sub-committees of the local and regional drugs task forces have been assigned an important role in the development of interagency protocols. The report recommends a significant role for the HSE in co-ordination of rehabilitation, including chairing the planned National Drugs Rehabilitation Implementation Committee (NDRIC) which will have responsibility for overseeing and monitoring the implementation of the recommendations of the report. It also recommends

the employment by the HSE of rehabilitation co-ordinators for the addiction services. In addition to recommendations in relation to improved provision of detoxification and treatment services, the report recommends that the housing, childcare, family support, educational, health and employment opportunities (including increased community employment places) for recovering drug misusers should be addressed through specific initiatives in a more focused way, and the report itself makes a number of specific recommendations in each of these areas.

Currently, there is no agreed model for interagency co-operation. In partnership with the Homeless Agency and based on learning from the EQUAL Initiative developed in a local drug task force, a Progression Routes Initiative is being trialled with 25-30 projects in Dublin's inner city. The pilot includes both drugs and homeless services.

5.3.8 Treatment of young people

In Ireland most children are referred to drug treatment by families or the social services but rarely through criminal justice. The NDTRS data indicate that almost all young people (aged between 11 and 14 years) in Ireland were treated at outpatient services in 2006. The main treatments provided were counselling (30, 59%), brief intervention (26, 51%) and family therapy (4, 8%). Almost one-quarter (23%) of clients received more that one treatment type in 2006.

In 2005 in Ireland, the Working Group on Treatment of Under-18 year-olds Presenting to Treatment Services with Serious Drug Problems recommended an approach based on a four-tier model that would ensure that the services provided would be based on the specific needs of the child and their family; provide a full range of drug-related education, prevention and treatment interventions; and be competent to deal with the complex ethical and legal issues surrounding such interventions. The working group agreed that the services would be adolescent-specific, local and accessible, have a combination of disciplines on site, and offer assessment, treatment and aftercare. In addition to the extra resources required to address the needs of these young people, it was suggested that greater co-ordination could maximise the impact of existing services. The report is being implemented on a phased basis. Adolescent specific services have been established in Dublin and the process of establishing one in the south-east of the country is under way.

Arrest referral schemes provide information to young drug-using arrestees about appropriate services and facilitate referral to treatment.

5.4 Gender issues

5.4.1 Pregnant women/families with small children

In 1999, the then Eastern Regional Health Authority introduced a formal statutory response to the increasing numbers of pregnant women reporting

with problem drug use through the establishment of a specialised drug liaison midwife service. This service is provided through three drug liaison midwives employed by the HSE, one linked to each of the three Dublin maternity hospitals. The aims of the post are twofold. First, it integrates the addiction services and the maternity services in Dublin and, second, it supports and educates the women during their pregnancy by providing holistic care that addresses their physical, psychological and social needs.

The report of the Working Group on Drugs Rehabilitation acknowledges that lack of childcare facilities presents a barrier in accessing treatment and rehabilitation options for many, women in particular. The report recognised that, while there was some existing provision for children of drug users, often through community-based projects developed through LDTFs, there was a need for an audit of gaps in existing provision. In addition it recommended that the HSE, in conjunction with the Office of the Minister for Children, should decide on how best to integrate childcare facilities with treatment and rehabilitation services and subsequently progress the matter. The report also recommended that childcare services for the children of problem drug users should adopt an approach focused on the development of the children and that parenting programmes for problem drug users should be further developed and implemented taking evidence-based best practice into account.

A number of projects funded through LDTFs provide after-school and evening support and activities for the children of drug users. A range of family support projects for families of drug users are funded through local and regional drugs task forces. A national Family Support Network for these families is in place and has just received additional funding to consolidate its work. Families of drug users can also avail themselves of support through more generic services such as the Family Support Agency, the Money Advice and Budgeting Service (MABS) and the Springboard projects for "at risk" children and their families.

5.4.2 Other gender issues

There are a number of drug services/projects specifically for women drug users. These include a residential therapeutic community (Ashleigh House) and the SAOL Project, a person-centred, community-based programme for women in treatment for drug addiction which aims to create positive meaningful change in the women's lives through an integrated programme of education, rehabilitation, advocacy, childcare provision (with a focus on early childhood education), progression and aftercare support. The former is seeking to have a more child-friendly environment through provision of crèche and childcare facilities linked to an outpatient detoxification phase in its programme while the latter has an associated SAOL Beag Children's Centre which is a quality early years and out-of-school service for children

aged from 0-12 years. Sessional places are available for children of parents who are participants in the SAOL Project.

5.5 Treatment within the criminal system

There are a number of formal and informal opportunities for diversion from the criminal justice system (CJS) within Ireland and they also provide treatment opportunities for those with addiction problems (Connolly, 2006). The Garda Síochána (police) provide a variety of programmes such as arrest referral schemes and the Juvenile Liaison Scheme to engage at risk individuals before they are brought to court. The Gardaí, like the Probation Service, provide a wide range of services and engage in partnership working with geographically based drug task forces, HSE drug treatment services and other fora to promote a social inclusion and drug treatment and rehabilitation agenda.

Treatment opportunities are available to the courts via referral to the Probation Service who can provide pre-sentence reports outlining the possibilities for engaging offenders in terms of treatment, supervision, offending behaviour and risk management. Supervision may be undertaken via use of formal probation orders and community service orders. The main process by which the Probation Service engages offenders is by way of supervision during deferment of sentence, for both district and circuit courts, rather than time limited probation orders. There is an argument to suggest that this is a more effective way of addressing addiction issues as the court hears the evidence and upon finding the charges proved postpones sentencing on condition that the offender responds to supervision and possible treatment conditions. Within Dublin there are also specialised drug treatment courts (Butler, 2002; Farrell, 2002).

There are also opportunities for drug treatment within prison and for co-ordinated court and executive determined treatment and supervision following release. Continuity of methadone maintenance treatment is provided for all sentenced and released offenders and is monitored by an audit system. Accesses to counselling and nursing services have been recently introduced as part of the Irish Prison Services Drug Policy. The Irish Prison Services Drug Policy seeks to balance supply reduction with treatment needs.

Co-ordination and continuity of services for offenders with a drug misuse problem is a major problem for many jurisdictions (Kothari et al., 2002; Pugh, 2004; Comiskey et al., 2006; Pugh and Comiskey, 2006). However, several initiatives, including a major IT-based shared care planning and integrated care pathway case management system, will address overall continuity of care issues and address the client service objectives outlined in the Health Service Executive Transition Plan.

6 Special issues

6.1 Rehabilitation

An important current issue and resource challenge for the addiction service in Ireland is the implementation of the report of the Working Group on Drugs Rehabilitation published in 2007. This report recommends a client-centred model of rehabilitation underpinned by case management, protocols for inter-agency working and service level agreements. Since the report has taken a holistic definition of rehabilitation, viewing it as beginning with the client's first contact with the treatment system, it has a number of implications for the statutory treatment services. It requires underpinning with improved infrastructure in terms of detoxification beds, residential treatment/rehabilitation facilities and step-down/aftercare beds. In addition, the HSE has been given a key co-ordinating role in implementation of the report and in chairing the proposed National Drug Rehabilitation Implementation Committee. The original impetus for the report was concern to improve progression of opiate users on methadone substitution. However, in the past few years cocaine use, the misuse of prescribed medication in conjunction with illicit drugs, and poly-drug use generally, have posed challenges to the delivery of services. This has led to the reorientation of services currently underway and an associated programme of up-skilling of staff to meet the more varied pattern of presenting need.

6.2 Prevalence of alcohol in the environment

The past decade in Ireland has been characterised by unprecedented economic growth and prosperity. This has coincided with an unparalleled increase in alcohol consumption, and drinking patterns that have become highly problematic. Ireland now has one of the highest levels of alcohol consumption in the European Union (EU). In 2003, Irish people consumed 10.6 litres of pure alcohol per person. The EU average consumption was 9.3 litres of pure alcohol per person. Binge drinking is a common drinking pattern including among young people. While bringing problems in its own right it also impacts on drug treatment services. The acceptability of heavy drinking and the increase in off-trade outlets (e.g. petrol filling stations, supermarkets) can complicate the rehabilitation process for recovering drug users. Alcohol also acts as a gateway to other drugs for young people. Currently alcohol issues fall within the remit of the National Drug Strategy only in relation to under-18 year-olds and where it is an aspect of poly-drug use. Under Action 80 of the National Drug Strategy a working group, under the leadership of the Department of Health and Children, is currently examining how synergies can be improved in the way in which alcohol and drug issues are addressed and whether a combined strategy is the way forward. Regulation of alcohol supply falls within the remit of the Department of Justice, Equality and Law Reform which has recently established a working

group to examine a range of issues related to supply, in particular in the off-trade sector.

6.3 Quality issues

The Report of the HSE Working Group on Residential Treatment and Rehabilitation (Substance Use), published in February 2008, recommended that a national quality assurance scheme for all four tiers of the alcohol and drugs services be established. The HSE is seeking to have Quality in Alcohol and Drug Services (QUADS) and Drug and Alcohol Occupational Standards (DANOS) as benchmarking standards for the drug and alcohol service. The HSE National Service Plan for 2008 commits to commencing work in this regard.

6.4 Human resource issues

In the Irish health care system general practitioners and community pharmacists are not employees but independent contractors. This means that their participation in the methadone treatment scheme is voluntary. The fact that there are currently 247 general practitioners and 427 pharmacists participating in the scheme is a positive feature of the treatment system enabling services to be delivered in a low profile client-friendly way in local areas. The voluntary nature of the scheme, however, has led to some difficulties in recruiting general practitioners in some regions outside the Greater Dublin area to which opiate use has now spread. There is now a National General Practitioner Co-ordinator in place whose role is to encourage and support the recruitment and training of additional level 1 and level 2 general practitioners outside of the eastern seaboard regions. It is targeted that this will result in the growth of general practitioners in the methadone scheme within these regions.

7 Strengths and weaknesses

7.1 Strengths

7.1.1 Highly qualified staff

A key strength of the drug treatment system in Ireland is the high quality of the staff involved in its delivery. The statutory treatment system is a consultant-led service (by consultants in addiction psychiatry) which includes in recent years a number who specialise in addiction in adolescents. The participation by means of contractual arrangements of specially trained general practitioners and pharmacists in the methadone treatment scheme has enabled the provision of a locally based substitution service for clients who are sufficiently stabilised to avail of this. In addition the Health Service

Executive treatment service employs a range of other staff including psychiatrists, nurses, outreach workers, counsellors/therapists, psychologists, administrative staff and general assistants.

7.1.2 Client-centred provision

The treatment services aim to respond to clients in a non-judgmental way based on their particular needs and to that end a spectrum of services is provided ranging from outreach/needle exchange through to drug-free residential services and more recently a focus on improving rehabilitation services to facilitate reintegration. The overall aim is to provide locally based services which are user-focused. A specialist treatment clinic and a system of satellite clinics are available to deal with more complex cases.

7.1.3 A partnership approach

A strength of the Irish drug treatment system is a partnership approach between the statutory, voluntary and community sectors which in fact underpins all the pillars of the National Drug Strategy. Local and regional drugs task forces have treatment and rehabilitation sub-committees which bring these stakeholders together. While this can at times lead to tension in relation to respective roles, overall it could be said to facilitate innovative approaches and greater flexibility in the tailoring of services to the needs of drug misusers and their families.

7.2 Weaknesses

7.2.1 Pressure on capacity

The increased prevalence of drug use, in particular poly-drug use (including cocaine) and the spread of drug use generally (including opiate use) outside the Greater Dublin area has exposed gaps in services provision, for example in the geographic distribution of services such as detoxification beds, needle exchange and general practitioner involvement in the methadone treatment scheme in the regions outside the east and has highlighted the need for the reorientation (currently underway) of treatment services more towards poly-drug use. The need to increase the capacity of the treatment services overall is an ongoing resource challenge.

7.2.2 Difficulties in service access for people with psychiatric co-morbidity

There are difficulties in access to mental health services for people with co-morbid addiction and mental health problems.

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The Netherlands

1 Demography

The Netherlands is a small but densely populated country. It is 41 526 square kilometres in area and has a population of 16 645 313 inhabitants (July 2008 estimate), resulting in a population density of some 400 inhabitants per square kilometre. The country is situated in and around the delta of two big rivers in north-western Europe and is an important economic transport centre. It has 11 provinces, some 25 regions and 443 municipalities (2008 estimate).

2 Epidemiology of drug use

In the Netherlands the National Drug Monitor (NDM) provides annual data on drug use and drug-related problems. The figures below are mainly from the most recent report (2008). In the general population aged 15-64 years old, the percentage of current cannabis users remained stable between 2001 and 2005 (in 2005, 3.3% or 363 000 users). In the same period current cocaine use has also stabilised among the general population (in 2005, 0.3% or 32 000 users). Among younger people current cocaine use (particularly snorting) is considerably more prevalent in recreational settings (up to 19%). Current amphetamine use in the general population is increasing although still fairly low (in 2005 this was 0.2%, accounting for 21 000 people). Current ecstasy use remained stable in this five-year period. In 2005 it was 0.4% (40 000 users). In the nightlife scene, ecstasy is still a much-used drug, particularly at raves and dance parties. In 2001 (most recent estimate) there were between 24 000 and 46 000 problem opiate users in the Netherlands. Of the EU-15 member states, the Netherlands together with Greece and Germany has the lowest number of problem users per 1 000 inhabitants aged between 15 and 64 (2-3 users compared to 8-9 in Italy and Spain and 10 in the UK). The Dutch opiate user has on average grown older over the years.

Changes in the number of direct drug-related deaths were inconsistent during the past decade. The figure increased prior 2001, decreased in the years after, rose again in 2004 and declined for the second time in 2005, 2006 and 2007 (in 2007 it amounted to 99 cases).

Patients infected through injecting drug use comprise 5% of the total infected population. This indicates a substantial relative reduction of this mode of transition since the start of the national HIV/Aids registration system in 2002. A new, regional study has recently been conducted. Only a minority of Dutch opiate users inject their drugs, the majority smoke heroin.

3 Short history of drug treatment

The organisation, implementation and co-ordination of addiction care is the responsibility of regional or local authorities or the treatment provider itself. This is due to the decentralised structure of Dutch addiction care. During the past six years more than 30 addiction treatment organisations have (in most cases) merged with mental health organisations resulting in some 15 regional organisations. Approximately half of these larger organisations offer both care for mental health disorders and addiction problems. Treatment is in most cases either mental health care or addiction care. Modalities of integrated care, provided for dual diagnosis patients, are still rare. The mergers have been initiated for economic reasons but also for facilitating combined or integrated treatments for dual diagnosis patients.

All types of treatment (ranging from a variety of detoxification strategies to psychosocial treatment options and combinations) are mainly delivered by these non-governmental addiction care facilities on a regional level, each one with several localities. Pharmacological treatment is also provided by some physicians (general practitioners) but this is mainly done in Amsterdam, not elsewhere. For addicted clients who can afford the costs, (outpatient) addiction treatment is also offered by a growing number of private organisations and privatised sub-organisations within regional organisations of addiction care.

The funding system for health care, including addiction care, has changed recently. In 2006 the National Health Insurance Act came into effect. The new national system is a private health insurance operated by private health insurance companies, which are legally obliged to accept every resident in their area of activity (the principle of risk equalisation). All treatments, including addiction treatment, are paid for by this new act. In addition, on a local (municipal) level services are paid for by the Social Support Act, for example hostels and home facilities for stabilised drug users, drug consumption rooms. Funds may also come from the Ministry of Health, Welfare and Sports. The Ministry of Justice pays for treatment programmes for addicts with judicial contacts (e.g. those arrested, in custody or in prison). Detoxification and residential treatment is also funded by the national health insurance scheme.

Last but not least, there are special project and/or research funds targeting experimental treatments (e.g. testing the effectiveness of the community reinforcement approach combined with incentive-based strategies (vouchers)). These kinds of project-specific (thus time-bound) research funds either emanate from the Dutch Research and Development Council (ZonMw) or from the long-term policy programme from the Netherlands Mental Health Organisation (GGZ Nederland). Both are intermediary organisations that

receive their funding budget from the Ministry of Health, Welfare and Sports.

The Netherlands Mental Health Organisation is responsible for national co-ordination of the regional and local facilities for the mentally ill and addicts and it also stimulates the implementation of new methods for prevention and treatment based on scientific evidence (evidence-based mental health and addiction care). Since 1999 this organisation has funded a long-term policy programme aiming to support an improvement in the quality of addiction care (Scoring Results programme). This programme funds studies in the field of addiction care. The first phase (1999-2003) has been evaluated (Mulder and Schippers, 2004). During this phase 23 research projects were conducted. The output of these studies ranges from exploratory reports, measurement instruments and review studies to working books, intervention modules, guidelines and protocols. Topics included drug consumption rooms, treatment indication and routing, clinical crisis intervention, self-help, substitution treatment and interventions that have (on average) been proven effective, such as lifestyle interventions. The website (www.ggznederland.nl) gives an overview of results of the first period of this programme in English. The second phase of this programme (2004-2008) focuses on further developing protocols, on the implementation of guidelines and on starting specialised courses in professional training and education in order to improve the expertise of future professionals (Van Es, 2004; Van Es et al., 2005). During its existence, between 1999 and 2007, this programme has received €2 450 000 from the Ministry of Health.

4 Services

All organisations of addiction care provide detoxification treatment, substitution treatment and drug-free treatment (psychosocial interventions).

Most drug-related treatment, including substitution maintenance treatment, occurs in outpatient settings for both addicts on illegal and legal drugs and both male and female clients.

The most important treatment targets are combating acute intoxication, supporting stable abstinence, stabilisation of drug use, reduction of health problems and optimal social integration (Van den Brink and Geerlings, 1999).

Pharmacological treatment of dependence on illegal drugs (mainly opiates) is mainly through the prescription of naltrexone. Maintenance or substitution treatment predominantly uses methadone and, on a small scale, buprenorphine (Van den Brink and Geerlings, 1999).

Drug-free treatments are used for drug dependent people in judicial settings (e.g. supportive interventions relating to money, housing or work), in experimental settings (e.g. the voucher-based community reinforcement approach)

and in general addiction care settings (variants of the lifestyle training, family-based therapies, and other psychosocial interventions). Psychosocial interventions are generally known to be used in treating opiate addiction to complement medication assisted treatment in order to attain longer term effectiveness after the detoxification phase. Cannabis, cocaine or ecstasy problems are generally treated with variations of cognitive-behavioural treatment, because effective medication (e.g. amantadine, bromocriptine) is still lacking. There are no specific admission criteria for drug-free treatment.

As part of the already mentioned Scoring Results programme, different intensities of lifestyle interventions that are partly based on cognitive-behavioural treatment have been introduced. Choices for one type or another are mainly dependent on individual treatment professionals and client preferences. Recent developments focus on drug-free treatment modalities for cocaine and cannabis users, in response to the increased treatment demand of this group of drug users.

The most socially excluded addicts are those who do not only live on the streets, but also avoid contact with regular addiction care. Moreover, these hard-to-reach, hidden addict populations tend to cause a public nuisance. To reach these treatment-refractory addicts, Dutch addiction care developed *bemoeizorg*, which is a special form of interferential care. A practice-based guideline was developed on how to apply this kind of care (Doedens et al., 2004). The main aims are to contact these addicts and to keep in touch with them by means of intensive case management. Given the special skills that are required to practice interferential care successfully, and given the need for more specialised interveners, several initiatives were taken to train professionals for this work.

Hostels are present in several cities in order to support and acquaint drug addicts with regular living circumstances, giving them a roof over their head. Home facilities were also created for stabilised older addicts.

User rooms or drug consumption rooms are available in a number of cities. These rooms offer an escape for drug users from the harassments involved in street living. They offer a quiet environment for drug use with reduced risk of dangerous side effects. Medical and social care is available and public nuisance on the streets is reduced.

During their stay in prison, drug users can participate in intramural clinical programmes. The prison system has recently introduced selectivity and differentiation. Selection for entering resocialisation programmes is prioritised for offenders who have a longer sentence and for whom an improvement can be expected. Differentiation implies that offenders in remand custody stay in a basic regime and convicted offenders with a relatively short custodial sentence cannot enter resocialisation programmes. For every detainee, aftercare is prepared by social service workers in the prison facility.

In some prison facilities drug users can participate in resocialisation programmes in drug-free addiction support units (*Verslaafden Begeleidingsafdelingen,* VBA). The 15 drug-free units offer a programme for addicts who are motivated to stop their drug use, and who are eligible for a programme preparing them for treatment outside detention.

"Quasi-compulsory" treatment is nowadays the prevailing option for drug users in prisons. It is offered as an alternative to prison. This option will be strengthened in the future. In 2006, there were more than 3 000 referrals to care programmes from the criminal justice system. Most referrals involve placement in outpatient/semi-residential addiction care (1 194 times) or residential addiction care (934 times).

In the Netherlands, two organisations for addiction care have already established specialised clinics for addicted young people. In the city of Groningen, Verslavingszorg Noord Nederland operates the Bauhuus (Verslavingszorg Noord Nederland, 2007) and in The Hague, Parnassia operates the Mistral (Parnassia, 2007a). Moreover, in Amsterdam, JellinekMentrum founded a new specialised clinic for addicted youngsters (Van Delft, 2007b), while the institute for addiction care Novadic-Kentron, in co-operation with the regional institute for mental health, founded a youth clinic in the city of Eindhoven (Jongerius, 2007).

Far from treating addiction as an isolated problem, the Bauhuus and the Mistral target the problem of addiction at a more in-depth level. In these programmes, addictive behaviour is seen as a symptom of underlying problems in individual psychological development. Young addicts are therefore addressed at their respective developmental level, especially with regard to the way in which they handle their emotions. Special attention is given to the young addict's (often problematic) way of attaching to other people. It is assumed that behind the addiction problem, underlying psychopathology is present or sublime. For example, addiction may result from having been abused as a child and not being able to maintain secure relationships with others. The escape chosen may be alcohol or drug abuse, with the consequence of dependency coming on at an early age (Vos et al., 2001).

After an experimental phase, treatment options for dual diagnosis patients have now started to be on the increase during the past few years. To date there are several centres that also focus on this target group. This group does not deal with the use of specific drugs and specific mental health disorders and treatment has to be adapted to many possible combinations of problems. A general guideline was published, but (integrated) treatments for this target group are still in development and their effectiveness is still being studied.

Finally, the treatment capacity for the prescription of medical heroin that started in 2002 has been extended to more cities. In 2006, 815 treatment

places in 18 municipalities were approved by the government. By mid-2008 about 600 slots were taken up, the rest will follow in 2009.

5 Strengths and weaknesses

Methadone treatment was first criticised because in general it was just restricted to methadone distribution without providing the often necessary medical care or (if wanted) additional psychosocial interventions. Initiatives have been taken to improve this situation and a guideline was published.

There is still no nationwide empirical overview of what specific types of treatment interventions are in use in the Dutch addiction care system. This overview would facilitate an evaluation of the evidence base of the interventions in practice. Furthermore, the large regional centres that were the product of the mergers between former addiction care and mental health care centres have not yet resulted in the availability of sufficient integrated care for dual diagnosis patients. The sense of urgency for doing this is growing.

After years of publishing knowledge about effective treatment options (the evidence base), guidelines and protocols, several variants of evidence-based interventions (e.g. lifestyle training, partly based on cognitive-behavioural treatment) are increasingly trickling down to professionals and the practice of addiction care. Several university chairs were established covering evidence-based addiction care during the past decade and professional education for addiction physicians and other professionals is increasing in quantity and quality (Van Es et al., 2005). Treatment via the Internet is now being explored and developed. The Netherlands has an Internet density of nearly 90% thus this option considerably enlarges the coverage rate among hidden populations of alcohol and drug dependents.

6 References

6.1 Literature

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6.2 Websites

This list contains a selection of Dutch websites of organisations related to treatment of drug dependence:

Drugs and Alcohol Info Team of Brijder Addiction Care – www.drugsinfoteam.nl

Unity: educational peer project in Amsterdam – www.unitydrugs.nl

Jellinek Addiction Care Amsterdam – www.jellinek.nl

Centre for Drug Research, University of Amsterdam – www.cedro-uva.org

Intraval: Bureau for Research and Consultancy – www.intraval.nl

Amsterdam Institute for Addiction Research – www.aiar.nl

Objective information on drugs for the general public – www.drugsinfo.nl

Addiction Research Institute Foundation, Rotterdam – www.ivo.nl

Municipal Health Service of Amsterdam – www.ggd.amsterdam.nl

Care Information Systems Foundation – www.sivz.nl

HIV Monitoring Foundation (HMF) – www.hiv-monitoring.nl

Prismant: consultancy agency for the social care sector – www.prismant.nl

Nijmegen Institute for Scientist-Practitioners in Addiction – www.nispa.nl

Bouman GGZ (Addiction Care Rotterdam) – www.boumanhuis.nl

Brijder verslavingszorg (Addiction Care North Holland) – www.brijder.nl

Centrum Maliebaan (Addiction Care Utrecht) – www.centrummaliebaan.nl

Verslavingszorg Noord Nederland (Addcition Care Northern Netherlands) – www.vnn.nl

Parnassia, psycho-medisch centrum (Addiction Care The Hague) – www.parnassia.nl

Novadic-Kentron, netwerk voor verslavingszorg (Addiction Care North Brabant) – www.novadic-kentron.nl

TACTUS, Instelling voor verslavingszorg (Addiction Care Gelderland and Overijssel) – www.tactus.nl

GGZ Noord- en Midden-Limburg (Addiction Care Northern and Central Limburg) – www.ggznml.nl

Mondriaan Zorggroep (Addiction Care Southern Limburg) – www.mondriaanzorggroep.nl

Emergis – Centrum voor Geestelijke Gezondheidszorg (Addiction Care Zeeland) – www.emergis.nl

Luxembourg

1 Demography

The Grand Duchy of Luxembourg covers a total surface area of 2 586 square kilometres.[10] As at 1 January 2007, it had a total population of 476 000, including 240 400 women. There were 198 300 foreigners, equating to 41.6% of the population. The 73 700 Portuguese nationals make up the largest proportion of foreigners in Luxembourg (15.5%), followed by the 25 200 French and 19 100 Italian nationals (5.3% and 4% respectively). The population may be broken down into the following age brackets: 67.6% are of working age (aged 15-64), 18.3% are children (aged 0-14) and 14% are senior citizens (aged 65 and over).

2 Epidemiology of drug use

Since its inception in 1993, the EMCDDA's National Focal Point (NFP) has developed and maintained an epidemiological monitoring system for the population of problem drug users identified by the national institutional network (RELIS). Operational since early 1994, RELIS consists of a multi-sectoral information network including specialised treatment centres, general hospitals, outpatient clinics and the competent judicial and criminal authorities.

Data is collected according to a standardised, anonymous procedure. The efforts made since 1994 have resulted in the compilation of a national data base, updated annually. In particular, it is used:

- to ascertain the prevalence and impact of the problem use of illicit drugs in Luxembourg and highlight trends;
- to monitor the profiles of those listed, without revealing their identity;
- as a scientific tool and data pool for research work;
- in the long term, to assess new trends and the impact of certain forms of intervention on the behaviour and characteristics of the drug-dependent population.

As the method implemented is of a scientific nature, the data collected and the findings of research co-ordinated by the NFP assist in the political decision-making process when it comes to introducing new action plans to combat drug dependence.

10. Central Statistics and Economic Research Office (2007), *Le Luxembourg en chiffres*. STATEC. Luxembourg.

According to the most recent data, the number of problem drug users in Luxembourg is currently estimated at 2 500 to 2 800 (among 15-64 year-olds). The national information and epidemiological monitoring network identifies anyone engaging in problem use of either illicit HRC (high risk consumption)[11] psychoactive substances or legal psychoactive substances diverted from the therapeutic use for which they are medically prescribed, as well as anyone falling into the aforementioned categories who has made contact during the year with one of the institutions belonging to the RELIS network.

The gender distribution (76% men, 24% women) reflects that found within Luxembourg's various facilities for drug addicts. Of the respondents, 53% are of Luxembourg nationality (RELIS, 2006). The proportion of foreigners among the national drug-dependent population has increased intermittently since 1994. The foreign population is dominated by Portuguese nationals (39%). The latter are the only group to be significantly over-represented in comparison with their distribution among the general population.

The main substance for which treatment is requested is heroin. Prevalence rates are about 70-80% (60% intravenous/20% non-intravenous). Preference for intravenous heroin use increased by 10% between 2005 and 2006. Multiple drug use is the most common form of consumption (88%). The sub-group of intravenous heroin users has the highest average age of all treatment groups (32 years, 6 months).

The proportion of people citing cocaine use as their main reason for requesting treatment rose significantly in 2004 and 2005 (20%), but dropped again in 2006 (14%). The average age of those requesting treatment for a cocaine preference is 27 years, 1 month.

According to an epidemiological and methodological research paper on deaths linked to illicit use of psychoactive substances (Origer and Delucci, 2002), the number of cases of overdose in relation to the general population of the Grand Duchy of Luxembourg was 6.43 deaths by overdose per 100 000 inhabitants in 2000. Deaths by overdose account for a proportion of the estimated total number of problem users of illicit drugs in the Grand Duchy of Luxembourg ranging from 0.48% in 1997 (n=2 100) to 1.1% in 2000 (n=2 450); the proportion was 0.77% in 1999 (n=2 350) (Origer, 2001). Taken as a proportion of the total number of deaths from all causes recorded by police, the variations are less significant: 1.346% in 2000, 1.361% in 1999 and 1.333% in 1997.

A recent research paper entitled "Prévalence et propagation des hépatites virales A,B,C, et du HIV au sein de la population d'usagers problématiques

11. Translator's note: term specific to Luxembourg (see http://stats05.emcdda.europa.eu/en/page032-en.html).

de drogues d'acquisition illicite" ["Prevalence and propagation of viral hepatitis A, B, and C and HIV among the population of problem users of illicitly acquired drugs"] (Origer and Removille, 2007) showed that self-reported data are not an accurate reflection of prevalence, but that the latter does coincide satisfactorily with the self-reported data supplied by the RELIS epidemiological monitoring system. The hepatitis C prevalence rate among the total survey population (1 167 problem drug users were approached, yielding 397 successful contacts) was 71.4%, compared with 81% among ever injectors.[12] The highest prevalence rate (83.3%) was found among respondents in prison, followed by those in residential treatment centres (75.4%) and outpatient treatment centres (58.2%). The hepatitis B prevalence rate among problem drug users is 21.6%, compared with 24.7% among ever injectors. It is 16.4% in outpatient treatment centres, compared with 15.1% in residential treatment centres and 31.8% in prisons. As regards the prevalence of HIV, no acute cases were detected during the conduct of the study. The overall HIV prevalence rate is 2.9%, compared with 2.5% among ever injectors. The HIV prevalence rate in outpatient treatment centres is 1.9%, compared with 7.7% in prisons and 0% in residential treatment centres.

3 Organisation of treatment services

The Ministry of Health, which since the 2000 and 2004 legislative elections has been responsible for co-ordinating demand reduction work, has formulated two successive drug action plans (2000-2004 and 2005-2009). Work with drug addicts is based on a holistic approach focusing on the individual and his or her environment rather than the substance in question. Drug dependence treatment services are run by either foundations or non-profit associations. The latter are financed from the Ministry of Health's budget and must be accredited by the said ministry (ASFT Act of 8 September 1998).[13]

Treatment is defined as "any activity aimed directly or indirectly at improving the psychological state, health and/or social situation of a person dependent on one or more psycho-active substances". Such activities may be undertaken by a specialised institution or any body working in the psychological or medico-social fields. A request for treatment or intervention in the broader sense means any request for medical and/or non-medical intervention, emergency intervention or occasional consultations, any kind of request for assistance or any kind of longer-term work aimed at reducing the risks associated with toxic substance abuse. Nevertheless, this definition excludes: any contact in which drug use is not the main reason for the consultation; any contact made with general administrative agencies for the sole purpose

12. Ever injectors are people who have injected a drug for non-therapeutic reasons at least once in their lives.
13. Act of 8 September 1998 on relations between the state and bodies active in the social, family and treatment fields (which entered into force on 24 September 1998).

of securing social assistance; any request rejected for reasons specific to the person concerned; any contact by telephone or letter that is not followed up; any request aimed solely at obtaining practical information; any request made by family members or friends or any institution not belonging to the treatment network (a priest or teacher, for example).

Each treatment facility signs a special co-operation agreement for medico-social and therapeutic facilities, setting out general and specific conditions relating to both its own commitments (the services to be provided) and those of the state (financial contribution). The Health Ministry and management body work together within co-operation platforms set up to monitor the provision of services and agree on any changes to the strategies and methods adopted. The 1998 ASFT Act stipulates that applicants for accreditation must have sufficient qualified staff to provide treatment or support for users. The necessary level and type of professional qualification or equivalent training and the minimum number of staff depend on the services provided, users' needs and the facility's modus operandi. In terms of staff, under the Grand Ducal Regulation of 10 December 1998[14] each facility must be headed by a manager qualified in one of the following areas: medicine, the health professions, law, economics, commerce, psychology, education, sociology, social communication, occupational therapy, dietetics, teaching or special education. Each facility must have a minimum number of supervisory staff. *Inter alia,* the regulation specifies the minimum number of supervisory staff in each occupational category. Recognised professional qualifications for supervisory staff include Luxembourg diplomas and certificates – and foreign diplomas and certificates approved as being equivalent – qualifying the holder to work in the health profession or occupy a professional position in social welfare or treatment facilities, such as those awarded to nursing assistants, social workers, environmental health officers, youth workers, occupational therapists, nurses, psychiatric nurses, graduate nurse managers/educators, physiotherapists, doctors, speech therapists, remedial teachers, psychologists and psychomotor therapists.

The government accreditation required under the ASFT Act of 8 October 1998 serves as a quality control system. However, financing does not hinge directly on clearly defined evaluation requirements. NGOs must evaluate their work by whatever means they consider appropriate, and report periodically on their activities to the ministry responsible. Associations in the drug dependence field have developed specific evaluation strategies, generally in conjunction with outside evaluators.

Apart from detoxification centres, all drug treatment centres accept drug-dependent patients irrespective of the type of substance used. The number

14. Grand Ducal Regulation of 10 December 1998 on the accreditation of managers of medico-social and therapeutic facilities (which entered into force on 18 December 1998).

of requests for treatment from outpatient facilities and residential treatment centres stabilised in 2006, while there was a marked increase in the number of detoxification requests and approaches to low-threshold facilities. Specialised drug dependence treatment is free, and detoxification is reimbursed by the Sickness Insurance Fund. Following the reorganisation of the hospital system, the psychiatric departments of five general hospitals have offered detoxification services since July 2005. Multiple drug use including heroin is the main reason for detoxification requests. Detoxification units have seen a significant increase in the number of patient admissions (382 patients in 2004; +/- 600 patients in 2006). As part of a one- to two-week detoxification programme, medical treatment and psychological and social support are offered with a view to controlling and reducing withdrawal symptoms.

4 Services

The methadone substitution programme, co-ordinated by the Health Ministry and the Jugend-an Drogenhëllef Foundation (JDH), was set up in 1989. There was no legal framework for substitution treatment until 2001, however. The Act of 27 April 2001 amending the Act of 19 February 1973 (the basic law on drug dependence), as amended, introduced a legal framework for substitution and maintenance treatment. The Grand Ducal Regulation of 30 January 2002[15] covers the practicalities of substitution. The new act regulates substitution treatment in general, rather than legalising a single, nationwide substitution programme. According to the act, prescribing doctors and specialised associations must apply for accreditation for substitution treatment and undergo training. The act mentions, *inter alia*, the need to put in place appropriate systems to monitor multiple prescriptions (such as a central register of substituted patients). It should be noted that, subsequent to the application of the new legal framework, a structured substitution treatment programme is still offered by specialised associations (JDH treated 105 patients in 2006, mainly with oral liquid methadone), and low-threshold substitution treatment by accredited doctors in private practice.

Until 2001, methadone and buprenorphine were prescribed as part of long-term treatment with a goal of medium- and long-term abstinence. There are cases, however, in which substitution treatment should be regarded as a harm-reduction or maintenance measure rather than a therapeutic act aimed at abstinence. The Grand Ducal Regulation of 30 January 2002 lists medicines and preparations containing methadone (in liquid form in the case of the programme, and in pill form in the case of low-threshold prescriptions)

15. Grand Ducal Regulation of 30 January 2002 setting out practical aspects of the substitution treatment programme for drug dependence.

and buprenorphine where the prescription mentions substitution treatment as a therapeutic indication. In addition, medicines based on morphine (salts) may be prescribed where the substances listed are deemed inadequate by the health professionals responsible. Lastly, the Grand Ducal Regulation allows heroin to be prescribed as part of a pilot project administered by the Health Directorate. The list of substitution substances may be modified rapidly by an amendment to the basic Grand Ducal Regulation. As well as dealing with the prescription of substances and medical assistance, the Grand Ducal Regulation on substitution treatment of 30 January 2002 lists a number of psychosocial counselling services to be provided by accredited specialised centres. Accredited doctors may refer substituted patients to treatment centres for psychosocial counselling.

Diverted Mephenon® (methadone in pill form prescribed by accredited doctors) is available on the drug market. This situation has arisen primarily as a result of uncontrolled multiple prescriptions of Mephenon® and dealing between patients and other drug addicts. There is no centralised substitution treatment register at present, and it is very difficult for accredited prescribing doctors to determine rapidly whether a patient is already being prescribed a substance by one or more of their colleagues. In this connection, a central substitution register is to be set up in conjunction with the Substitution Treatment Monitoring Committee, the national drug co-ordinator and the specialised treatment centres concerned. In June 2006, the National Data Protection Committee agreed to the establishment of such a register, which is expected to become operational in 2008.

The main outpatient clinic for drug addicts is the Fondation Jugend- an Drogenhëllef (JDH Foundation). It offers short-, medium- and long-term therapy, emergency intervention, social assistance and guidance and counselling. The JDH Foundation co-ordinates the national methadone substitution programme. Its headquarters are located in Luxembourg City, and it also has regional branches in the south and north of the country.

There is only one residential treatment centre for drug addicts in Luxembourg, located in Manternach (in the east). The Manternach Treatment Centre (CTM), attached to the Neuro-Psychiatric Hospital (CHNP), is designed to have an optimum capacity of 18 beds. It does, however, have a number of additional beds enabling it to deal with emergency situations or fluctuations in admissions.

The treatment concept is based on mutual assistance, gradual assumption of responsibility and the development of self-control. In addition to its work geared to medium- and long-term abstinence, the CTM also admits clients undergoing substitution treatment.

The centre's treatment programme provides for gradual progress, divided into three phases: motivation, development and reintegration.

The centre aims to provide drug-dependent residents with psychotherapeutic treatment. A multidisciplinary team dispenses family, individual and group therapy, based on psychosocial aspects and occupational therapy.

In addition to purely therapeutic intervention, the centre offers residents the opportunity to undergo training in a number of vocational fields. Its goal is to provide residents with psychological support and foster their long-term reintegration into society and working life. The cornerstones of its rehabilitation work include the quality of the vocational training courses offered, collaboration with a network of employers willing to hire former drug addicts, and high-quality social assistance aimed *inter alia* at arranging suitable housing for patients during the final treatment phase.

Owing to the limited number of residential treatment centres and the fact that they do not cover the full range of symptoms associated with drug dependence (dual diagnosis, for example), some patients are referred to specialised facilities abroad. Related costs are borne by the social security scheme.

According to the national information and epidemiological monitoring network, the mental disorders most commonly reported by clients in contact with specialised drug dependence facilities are anxiety, depression, neurosis, psychosis and borderline personality disorder. Residential treatment centres estimate that 10% of their clients demonstrate psychotic symptoms. Post-traumatic stress disorders are also common, showing similarities to borderline behaviour such as mood changes and self-destructive tendencies. Dual diagnosis patients are generally multiple drug users. Most treatment centres admit clients only if they have previously undergone detoxification treatment. Many dual diagnosis patients do not meet this requirement, and it is difficult to integrate them into conventional treatment in view of the need to apply consistent rules to all those requesting treatment. Luxembourg does not have a specialised facility for dual diagnosis patients; the social security agency's medical supervision department assesses, in conjunction with treatment centres, whether a patient may be referred to specialised facilities abroad. The social security agency has agreements with such facilities. Where this type of request is approved, the associated costs are borne by the social security scheme. Twelve Luxembourg City associations have been working together since 2006 to improve their client-focused activities (forming a network based on collaborative social work, quality of life and solidarity) and gearing their capacity to the specific needs of "chronic" clients. The 2005-2009 action plan to combat drugs and drug dependence provides for the establishment of a treatment facility for dual diagnosis patients.

Luxembourg has the following facilities outside the hospital system:

– The Fondation Jugend- an Drogenhëllef (JDH Foundation), Luxembourg's main outpatient centre for drug addicts, runs three

outpatient facilities (in the north, south and centre of the country) and a low-threshold facility, as well as co-ordinating the national methadone substitution programme.

– The Emmanuel Centre runs an outpatient and guidance centre for drug addicts and their families. It provides general information on dependence, draws up abstinence plans and offers assistance with personal problems unrelated to dependence;
– TOX-IN (run by the National Social Protection Committee, or CNDS) is an integrated low-threshold centre for drug addicts. It offers a day shelter, a night shelter with daily admissions and a drug consumption room.
– The Manternach Treatment Centre (CTM) is a residential treatment centre for drug addicts. It provides psychotherapeutic treatment for drug-dependent residents. A multidisciplinary team provides family, individual and group therapy, based on psychosocial aspects and occupational therapy. This is the only residential treatment centre for drug addicts in Luxembourg.

Luxembourg also has a treatment centre for alcoholics, the Useldange Treatment Centre, which offers inpatient and outpatient treatment including rehabilitation, psychotherapy, specialised therapies for women and men, and guidance, and works in conjunction with hospitals. The cost is reimbursed by the Sickness Insurance Fund.

The Rosport shelter, which is attached to the CHNP and works closely with the CTM, is designed for drug addicts in the process of becoming stabilised. It currently has 12 places.

The Neudorf post-treatment centre is run by the JDH Foundation. It cares primarily for patients having completed courses of residential treatment in Luxembourg or abroad. In 2000, the JDH Foundation also set up a specialised service designed to promote reintegration through the provision of housing, known as the "Niches Project". The starting point for the project was the realisation that a number of people in recovery do not have the necessary resources to secure suitable housing, which is a key stabilising factor at a particular stage in the reintegration process. The foundation rents out bedsits and flats, acts as a rental guarantor and sub-lets properties to the clients concerned. It managed a total of 26 dwellings in 2006.

Under the 2005-2009 action plan to combat drugs and drug dependence, the provision of housing by the CHNP and CTM and the JDH Foundation's "Niches Project" are to be consolidated and extended.

Inter alia, the 2005-2009 action plan provides for the establishment of a day unit offering vocational training opportunities and paid daily employment

to people suffering from a dependency illness. It is to be set up in the countryside, and will also offer medium-term accommodation.

The Médecins sans Frontières youth solidarity facility for minors (MSF-Youth Solidarity) bridges the health and judicial fields. It targets all users of lawful and illicit drugs under the age of 18 who are in trouble with the authorities, along with their families. The aim is to set up a network to promote co-operation between health and judicial authorities so as to facilitate the reintegration of young people in trouble. In 2006, MSF-Youth Solidarity launched the CHOICE pilot project in conjunction with the Ministry of Health. It is designed to provide rapid intervention, in the form of information meetings and discussion groups, for young people aged 12-17 who have been detained by the police for infringing Luxembourg's drug legislation, with a view to identifying alternatives to punitive measures.

The Neuro-Psychiatric Hospital's Adolescent Department treats at-risk adolescents aged 12-18 in a long-term care environment. It currently has six places.

The JDH Foundation's parenting service has supported pregnant women and drug-dependent parents since 2003. It seeks to enhance their parenting and child-rearing skills, with a focus on children's needs. A multi-disciplinary team works with operators from outside services and arranges home visits.

The Grand Duchy of Luxembourg has two national prisons, Luxembourg Prison and Givenich Prison. Section 9 of the Act of 27 July 1997 on the reorganisation of the prison system provides for the creation of a special medical section for drug-dependent prisoners. Under this act, a pilot project involving comprehensive care for drug-dependent prison inmates, known as Project TOX, was launched by a group of experts commissioned by the Ministry of Justice. The project ran from 2000 to 2005 and the aim was to put in place primary and infectious disease prevention programmes and to set up drug-free units. Its main goal was to integrate drug-dependent prisoners into a medical and psychosocial network with a view to reducing the level of post-release recidivism, risky behaviour and crime. The project's implementation had to be tailored to the differing situations and needs in the two prisons. Since 2003, both prisons have offered individual and collective intervention consisting of weekly discussion groups for drug addicts, visits by the staff of drug dependence treatment centres and special sessions as part of a recidivism prevention programme. All in-house services are actively involved in Project TOX, and work with specialised drug dependence treatment facilities. Givenich Prison's drug-free unit/treatment block became operational in early 2004. Generally lasting eight months, the programme includes individual and group therapy sessions. Project TOX has afforded an opportunity to introduce syringe exchange schemes within the prisons, to arrange treatment programmes with drug-dependent inmates, to promote

general health prevention and reduce the risk of recidivism and to educate staff about drug dependence. In 2007, a final evaluation report[16] recommended that the TOX project be continued within the prisons.

5 References

5.1 Websites

www.relis.lu – RELIS: Luxembourg Information Network on Drugs and Drug Addictions
www.jdh.lu – JDH Foundation
www.ms.etat.lu – Ministry of Health

A comprehensive list of specialised services in the area of drugs and drug dependence in the Grand Duchy of Luxembourg may be found on the following Internet site: www.cept.lu/pdf/06helfr.pdf

5.2 Literature

Origer, A. and Delucci, H. (2002). "Etude épidémiologique et méthodologique des cas de décès liés à l'usage illicite de substances psycho-actives: Analyse comparative (1992-2000)", Research Series No. 3. Luxembourg: EMCDDA Focal Point, Luxembourg-CRP Santé.

16. Trepos, J.-Y. (2007). *Evaluation interne du projet global de prise en charge des personnes toxicodépendantes en milieu pénitentiaire au Grand-Duché de Luxembourg*, Université Paul-Verlaine, Metz.

Switzerland

1 Demography

Switzerland is a small country of 7.4 million inhabitants covering a territory of 41 285 square kilometres. It is a federal state, made up of 26 cantons. The native language of about 65% of the population is German, 20% is French and 6.5% is Italian. A small fraction of the population speaks Romansh (0.5%) as their native tongue, while other non-official languages make up the remainder according to the Federal Office on Statistics' report 2005.

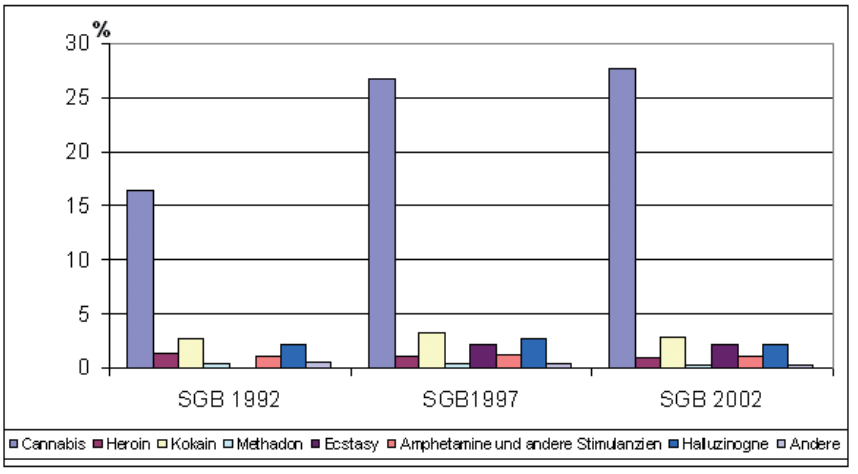
Since the adoption of the federal constitution in 1848 which gave only limited responsibility to the federal state in the field of health, the high degree of autonomy of Swiss cantons has moulded the Swiss health system. From this time until today, there has been a continuous discussion over the respective roles and responsibilities of the cantons and of the Swiss confederation leading, over the years, to a modest expansion in federal responsibilities.

Government responsibilities are segregated between the three different levels of governance: the confederation, the cantons (26) and the municipalities (approximately 2 850). There is considerable decentralisation of power to lower levels of government. Each canton has its own constitution, parliament, government and courts and the cantons hold all powers not specifically delegated to the confederation. The seven ministers who form the federal government are not elected by the people but by the parliament, which grants the four leading political parties at least one seat. The Swiss political reality is thus not built upon two major political forces – one being in power and the other in opposition – but rather on a multiparty system that tends to share power and influence.

2 Epidemiology of Drugs Use

In 2006 a study conducted in the majority of the Swiss injection facilities has shown that Switzerland has experienced a significant increase in the consumption of cocaine, while heroin consumption has either remained stable or decreased. The consumption of both heroin and cocaine has remained the most common form of use. A clear trend can be seen as heroin consumption has decreased in the past (see Figure 8) and there are fewer people starting heroin consumption. In the long run, this will have an impact on the therapeutic institutions in Switzerland as the treatment they offer will have to shift towards outpatient treatment. It will become necessary to approach this new "clientele" of addicts with different resources and a different degree of social integration than with heroin consumption.

Figure 8: Drug consumption in Switzerland (1992-2002) as a % of the population

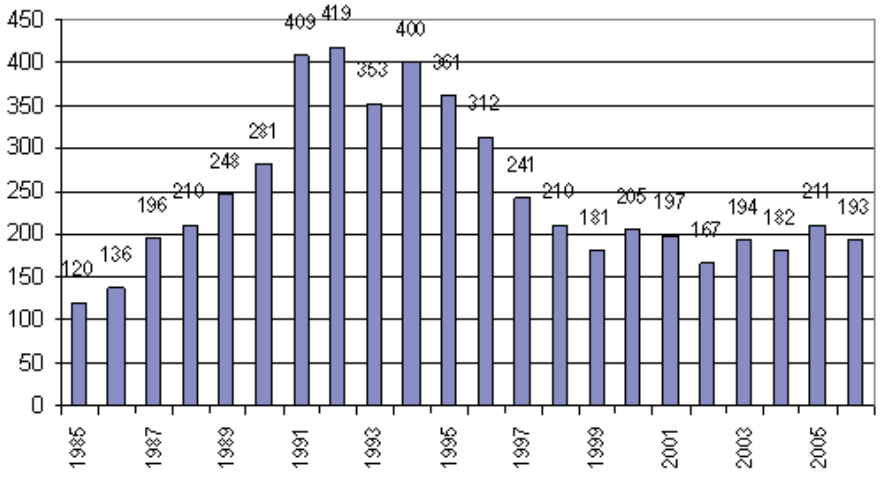


Key: Kokain = cocaine; andere Stimulanzien = other stimulants; halluzinogne = hallucinogens; andere = other.

Source: Federal Police Office (Fedpol) and Federal Health Office (BAG)

The mortality rate linked to drug consumption has fallen over the last decade in Switzerland (see Figure 9).

Figure 9: Drug deaths in Switzerland 1985-2006



A trend can be seen towards less intravenous consumption and the population of injecting drug users is clearly growing older.

3 Short history of drug treatment

In the first half of the 1990s the public regarded the open drug scenes as one of Switzerland's most urgent problems. Public pressure resulted in political intervention at all levels. Therefore, the Swiss drug policy, in general, was not established or developed in some cabinet or commission but took its shape over several years and the federal government began to take an active role and embarked on its four pillar policy consisting of measures in the areas of prevention, therapy, harm reduction and law enforcement.

In 1995 the last open drug scene, the "Letten" in Zurich, was closed. After that the importance attached to the drug problem in opinion polls decreased. Today only a handful of people still regard the drug issue as one of our country's most pressing problems. At the same time, the number of motions in parliament connected with drug policy has also fallen. Interest in drug policy on the part of the public and from politicians is thus currently very low, while at the same time a number of drug policy measures are being queried due to increasing pressure for public spending cuts.

In the area of therapy it is important that people suffering as a result of their drug dependency should be given effective help. It should be made possible for them to overcome their dependency. However, in certain circumstances some people either do not want to or are unable to quit using drugs (yet). In such cases the primary task is to keep open the existing options for them to overcome their dependency at some later point, to promote their health and to (re)integrate them into society. Preventing them from becoming marginalised is central to reducing the repercussions on both the individual and society – and the financial cost. A large selection of therapies (drug-free treatment services, methadone therapies, heroin prescription, inpatient and outpatient treatments) in every combination is needed to help addicted persons on the way to overcome their dependency.

The aims of therapy are to help drug users overcome their dependence, improve their physical and mental well-being and assure their social reintegration. There is a need for treatment options that go beyond the standard range available, allowing a differentiated approach for each person seeking help. These must therefore take into account an individual's dependence as well as other problem areas such as the social disadvantages suffered by drug addicts, their housing problems, unemployment and debts, and their social skills.

A wide range of residential and outpatient treatment options are available in Switzerland. Around half of the country's opiate addicts receive methadone treatment, and heroin assisted treatment has been a recognised option since

1999. The direct or indirect aim of all forms of therapy is to enable individuals to overcome their dependence and to achieve social reintegration.

4 Organisation of treatment services

Due to its federalist structure the federal government is responsible for ensuring the ongoing development of measures to reduce and prevent problems associated with drugs, drawing on scientific material to form its policies, while it is the cantons that are largely responsible for implementing policy.

The cantons have a statutory obligation to make addiction treatment programmes available. Under Article 15a, paragraph 2, of the Swiss Federal Law on Narcotic Drugs and Psychotropic Substances (BetmG) they have a duty to ensure that care is provided for people who require medical treatment or welfare measures. As part of this treatment, occupational and social rehabilitation is to be promoted. Each canton may fulfil these obligations on an intracantonal basis, by providing detoxification facilities and services involving varying degrees of intervention. For financial and organisational reasons, medium-sized and small cantons are not in a position to fulfil these obligations themselves. Appropriate services have to be purchased.

Since the treatment approach for drug-dependent persons is "biopsychosocial", those active in this field are doctors, psychiatrists, psychologists, nurses and social workers, the latter constituting the largest body of professionals involved. Drug addiction studies are now a component of the basic training proposed by the higher education institutions for social workers, and the theme of dependence is also gradually being introduced into the core syllabi for doctors and pharmacists. Over the last 15 years a considerable effort has been made to enhance the further training possibilities offered to all these professions and to make them as multidisciplinary as possible. The methods linked to the cognitive-behavioural approach are in widespread use. Now that the supply of further training has been adapted to demand, the focus is on improving its quality and incorporating it into study cycles that are consistent with the Bologna directives so as to ensure their recognition. A Master of Advanced Studies (MAS) course was introduced in 2006 for social workers and nurses. A national committee of training experts in matters of drug-dependence (Commission d'experts formation dans le domaine des dépendances CFD/EWS) is responsible for promoting and co-ordinating these training opportunities. In 2008 it is launching a competencies profile covering all addiction-related activities apart from prevention. It has also worked with a large number of European and Canadian partner organisations to set up an international discussion and exchange network on training in addiction matters – the International Think Tank – Education and Training on Addiction (I-ThETA).

General practitioners prescribing methadone (60% of programmes) constitute a special case. As each of them has only a few patients, they cannot devote much time to specialist training. Enhanced support measures have been developed in many regions of Switzerland to answer their specific needs and help them escape the isolation of their surgery: documentation, an Internet site, discussion groups for exchanging experience, hot lines staffed by peers with specialist knowledge, measures to foster co-operation with other professions (in particular pharmacists), short training courses run locally and regional conferences. All these measures are aimed at not only guaranteeing the quality of medical treatment, but also ensuring that a sufficient number of doctors are willing to offer substitution programmes (guaranteeing access to treatment).

Professional associations include the Groupement Romand d'Etudes des Addictions (GREA), the Fachverband Sucht and the Swiss Society of Addiction Medicine (SSAM).

5 Services

5.1 Detoxification

In Switzerland we can depend on 52 specialised detoxification institutions, 37 in residential or inpatient treatment (in hospitals or specialised hospital sectors) and 15 in outpatient detoxification programmes. Most of the institutions offer programmes for every substance (drug, alcohol, medicines); some of them are only for drug addicts, others only for alcohol addicts. Some of the detoxification institutions offer short therapy programmes of a few weeks. After detoxification, some patients follow either other in- or outpatient treatment programmes.

5.2 Evaluation/planning of treatment

5.2.1 Evaluation

All levels of the addiction aid system are evaluated. These evaluations are an integral part of the contracts entered into with service providers.

Evaluation of projects financed with public funds, in particular, serves as professional examination and development, as well as for (political) legitimisation at the level of cantons or municipalities.

For example the federal package of measures to reduce drug-related problems (MaPaDro I and II) was subjected to a comprehensive evaluation.

At the national level, the Swiss Federal Office of Public Health (SFOPH), in co-operation with research institutes, developed "act-info", an important structure for data collection to monitor all kinds of treatment. "Act-info" is a standardised national client monitoring system for addiction care,

including the following treatment sectors: outpatient treatment centres and psychosocial care (SAMBAD, 41 services), residential treatment for alcohol addiction (act-info-Residalc, 14 centres), residential treatment for drug addiction (act-info-FOS, 56 centres), methadone maintenance treatment (national methadone statistics, 17 cantons involved), and heroin prescription programmes (heroin-assisted treatment, 23 centres).

Act-info represents a synthesis of previous monitoring instruments and approaches. The main aim of act-info is to implement a Swiss monitoring system by collecting relevant data for people in addiction treatment, for example socio-demographic characteristics, data on life status at treatment entry and after treatment, details of addiction problems, drug use patterns and other areas. Act-info seeks to improve our understanding of care seekers requesting drug treatment and to identify trends of drug use at an early stage. Compatibility with international standards such as treatment demand indicators (TDI) is ensured.

Evaluations which are conducted by individual or groups of treatment facilities often focus on specific projects; funding at this level is a frequent problem.

Even though third party certification by the QuaTheDA quality management system (Qualität der Therapien im Drogen- und Alkoholbereich/quality of therapies in drug and alcohol education) is not considered an evaluation in the traditional sense it is still an important basis of feedback referring to treatment facilities.

5.2.2 Treatment planning – Structural level

In Switzerland the cantons and/or municipalities are responsible for the provision of the majority of addiction treatment facilities. They either provide these structures as part of their public medical health care or as part of their social care system.

Regarding medical care facilities, these can be autonomous institutions or specialised departments/services in cantonal clinics (such as medical services within cities, outpatient services, poly- or day-clinics, outpatient advisory services and others).

As part of social care these services can vary from assisted living, employment programmes and other day structures to medium- to long-term stays in residential settings with a wide-ranging social-therapeutic and rehabilitative mandate. Proposed medium- to long-term stays in inpatient settings can consist of various kinds of attended or accompanied living and occupational programmes and other day structures. The canton or municipality may choose to offer these services themselves or commission third parties

(private organisations, non-governmental organisations) to provide the required services.

5.2.3 Treatment planning –Individual level

At the institutional level, an individual therapy planning day can be described as standard. In the QuaTheDA quality system, an individual therapy plan is explicitly required for each type of treatment facility.

5.3 Treatment

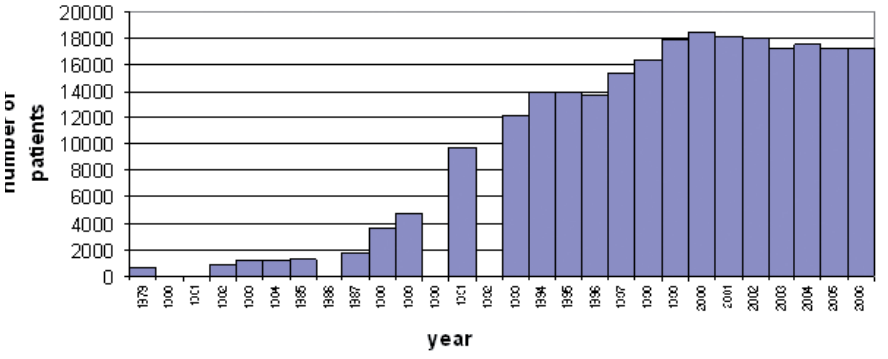
5.3.1 Substitution treatment

Methadone treatment

Methadone has been prescribed in Switzerland since the mid-1970s. At the end of 2006 around 17 000 of the estimated 30 000 opiate addicts were enrolled in a methadone programme. There has been a decline in the number of cases being treated, reflecting the reduction in heroin use in Switzerland. Methadone was given to both heroin users and those dependent on other hard drugs in the 1980s with the ultimate goal of weaning them off the substances to which they were addicted. Strict conditions were attached to this form of treatment, which was closely supervised; it was a highly structured option with restricted access. However, with the advent of Aids, methadone was made available on a less restrictive basis, meaning easy access (see Figure 10). It was realised that addicts needed treatment options that would help them reduce their illicit consumption of hard drugs and limit the spread of HIV, hepatitis and other infections. Methadone is used in prisons for the same reasons.

This form of treatment is dispensed by general practitioners in 60% of cases, and specialist facilities for the remaining 40%. Thanks to a decentralised network of private practitioners, good access to treatment is ensured in Switzerland. Efforts are made to integrate these private practitioners into the psychosocial support network and to assist them in dealing with these patients. For example, in 2007 the Swiss Society of Addiction Medicine published evidence-based medical recommendations taking account of current understanding of opiate dependence, whereby for a majority of patients their addiction constitutes a chronic disease with a high risk of mortality and of co-morbidity (psychiatric co-morbidity in 40% of cases, for example). This entails long-term treatment, with the objective of helping the patient progress from an unstable, worsening addiction to stabilised dependence. It constitutes a palliative medical approach, which in no way rules out periods of abstinence or a cure for a minority of patients. This therapy approach was presented at the National Conference on Substitution (NASUKO 2007) and is a matter of consensus among professionals active in the field.

Figure 10: Methadone treatment in Switzerland (1978-2006)



Heroin-assisted treatment (HAT)

In the early 1990s it was observed that the existing therapeutic options were not meeting the needs of some severely dependent individuals. These are addicts who, in spite of receiving various therapies, repeatedly relapse into dependence. They suffer from health and social problems and are exposed to a high risk of infection with HIV and/or hepatitis and are at risk of overdosing. Their frequent criminal activity to finance their drug habit places a burden on society. It was against this background that in 1992 the federal government approved a research programme designed to investigate whether heroin-assisted therapy could provide the treatment needed by this specific category of drug addicts.

The HAT involves strictly regulated and controlled prescription of pharmaceutical heroin as part of a comprehensive programme of psychosocial care and medical treatment, pursuing the following objectives:

– lasting participation in therapy;
– social integration;
– improvement of the individual's physical and mental well-being (reduction of the risk of infection with HIV and/or hepatitis, and the risk of spreading these diseases); and
– creating a basis for long-term abstention from opiates.

The research programme showed that this therapy improved participants' physical and mental well-being and their social integration. At the same time there was a massive reduction in drug-related crime and the consumption of non-prescribed substances declined significantly.

Heroin-assisted treatment was given a legal basis in October 1998 and is now part of the accepted range of therapeutic options. At the end of 2007 there were 21 outpatient centres and two prisons using this approach in Switzerland, offering a total of 1 444 places.

It must be stressed again that this therapy is only available to severely dependent drug users with serious social and health problems who are older than 18 years of age and have either discontinued or unsuccessfully completed at least two treatment attempts involving another recognised method. HAT is in no way intended as a replacement for other types of treatment, either based on abstinence or involving the use of other substances (e.g. methadone).

5.3.2 Drug-free treatment services

Switzerland has in place 91 institutions offering drug-free treatments lasting from a few months to at least one year. Patients must be detoxified before starting therapy. To be drug-free after therapy is only one of several aims. Others include (re)integration into society, the ability to live independently, the ability to work and have an occupation, and the ability to forge functional relationships and to participate in leisure activities. These social goals are sometimes hard to achieve, because they are not solely dependent on the will of the person but also on the structural and economic conditions of society.

Most of the drug-free treatment services offer personalised treatment, to be able to target the health and social needs of the particular individual and get better and longer lasting results.

5.3.3 Dual diagnosis treatment

In the 1990s dual diagnosis and drug addiction treatment was an important issue. The practice of drug addiction treatment showed that nearly all of the facilities had to deal with this problem.

Today most people with drug problems suffer from other diseases, so all of the concepts of drug treatment include co-morbidity. Either the facilities turn to professionals with training in dual diagnosis within their team or they work with specialists (doctors, etc.) in outplacement therapy.

5.3.4 In/outpatient

Inpatient therapy/residential therapy

This therapy designed to overcome dependence seeks ultimately to reintegrate dependent drug users into society and permit them to lead a largely independent life. The success of such therapy is measured by the achievement of the following milestones: a healthy lifestyle, no consumption of psychotropic substances, establishment of functional relationships, establishment

of worthwhile leisure activities, suitable accommodation arrangements and living on the right side of the law.

These include halfway houses, sheltered group accommodation and reintegration schemes. At the end of 2006, there were 1 500 places in residential therapeutic facilities. Three quarters of the therapy centres offer treatment programmes lasting at least 12 months. Some residential programmes offer prescribed narcotic drugs, such as methadone therapy.

A further 300 places were available in Swiss clinics or hospital wards specialising in drug withdrawal. Some regional hospitals and a growing number of outpatient facilities also offer withdrawal therapy.

Treatment in halfway houses lasts between one and six months. The focus is on helping individuals through the difficult stages of physical withdrawal and on planning their post-treatment. Relatively few such places are available.

Since 2001, most of the residential therapies apply and are certified through the Swiss quality standard known as QuaTheDA, set up by SFOPH in collaboration with experts. Since 2005 the quality standard was also introduced for outpatient treatment services.

Outpatient therapy

In addition to residential facilities, Switzerland has over 200 community-based counselling centres whose task is to prevent drug abuse and care for drug-dependent individuals. These are located in all the major cities and medium-sized towns and in some rural areas as well. Some counselling centres specialise in illicit drugs, while others cover all aspects of dependences An approach based on social, psychological and educational principles has been adopted that now underpins their work. About half the country's contact centres employ doctors so that substitution therapies can be prescribed. The other centres mainly handle clients on methadone programmes prescribed by the clients' own doctors. Counselling centres also provide assistance with admission to residential therapies and supervise post-treatment.

5.3.5 Drug and/or alcohol and prescribed drugs

Traditionally there are three types of specialist facilities, according to the type of substance consumed: illegal drugs, alcohol or a mix. In both outpatient and residential care a distinction is drawn between these three categories, and professionals specialise in one particular area. However, this separation is gradually being eliminated, and a growing number of facilities also offer treatment or support based on other criteria and/or for other substances (cocaine, cannabis, etc.) and/or for non-substance addictions (gambling, video games, etc.). In addition, nearly half of residential treatment facilities now offer patients the possibility of receiving substitution treatment as part of their therapy.

5.3.6 Availability/link to somatic and psychiatric treatment

In view of the solidarity-based social security system, the fact that sickness insurance is compulsory by law and the well-implemented addictions policy, facilities can easily be accessed by persons wishing to undergo therapy. Specialist facilities exist in the vast majority of cantons, and the offer is highly diversified. A broad range of services is provided: detoxification treatment, residential therapy, time out, post-treatment monitoring, counselling/assistance/support, risk reduction/aid for survival measures, substitution treatment and methadone/Subutex/heroin programmes, psychiatric treatment, somatic treatment, peer and family support.

Some of these services may also be accessed by persons subject to criminal justice measures or in prison (substitution, sterile equipment exchange schemes, commutation of sentence to a course of outpatient or residential treatment).

5.3.7 Rehabilitation services linked to treatment

Various services, such as family placement, halfway housing facilities, post-therapy living group, job or occupation opportunities, are closely associated with therapy or are linked to treatment. If needed for stabilisation and step-by-step integration, one or several of these are offered through residential treatment.

5.3.8 Treatment of young people

There are some outpatient programmes for young people with drug problems (cannabis, etc.) but only a few specialised inpatient addiction facilities offering therapies for young people under 18 years of age. Most of the minors with drug problems are first treated in outpatient facilities if possible. If the family facility does not work or there are other problems, such as school, behavioural or psychiatric problems, young people with drug problems are mostly placed in facilities adapted to their age, such as youth homes/educational homes that are more oriented to cope with problems associated with general development and youth.

5.4 Gender issues

5.4.1 Pregnant women with small children

We can assume that roughly 50% of addicted women and men are parents. However, there is no specific monitoring of this. Pregnant women may access special programmes, especially in the university hospitals of the larger cities in Switzerland. Drug-dependent women with children are accepted in one detoxification centre, in 16 inpatient and three partly inpatient institutions.

5.4.2 Other gender issues

Gender-specific addiction work has been continuously supported by the SFOPH since 1993. This includes work on scientific foundations and various other mandates to external experts. The mandate for the promotion of gender specific addiction work started in 1997. It comprises counselling, further education, public awareness-raising and the elaboration of instruments and documentation for experts, institutions and authorities.

Infodrog, the Swiss co-ordination and intervention centre, financed by the SFOPH, perceives gender aspects in all areas as a cross-cutting issue.

The website (www.drugsandgender.ch), also mandated by the SFOPH, offers an overview of current gender-specific provision in the field of addiction. In order to be listed, a set of clear criteria have to be fulfilled. At present, 74 inpatient and outpatient (also low-threshold) institutions in the area of addiction intervention meet these criteria.

Apart from SFOPH, the two other professional associations, Fachverband Sucht for the German-speaking part and GREA for the French-speaking part of the country, also offer platforms for information exchange, further education and general networking on gender issues.

5.5 Treatment within the criminal system

Up till today there has been no monitoring system for drug-therapeutic or harm-reduction measures within the criminal system. There are methadone maintenance programmes as well as defined “drug-free” prisons and there are two Swiss prisons offering a heroin-assisted treatment centre.

Regarding harm reduction and prevention, roughly one third of the prisons hand out condoms and in a few institutions sterile material and sterile syringes as well. However, there are no rules or regulations in force that are applicable all over the country.

At present a project is being planned for the elaboration of regulations regarding the prevention and treatment of infectious diseases as well as drug-therapeutic measures in the criminal system. This should take place in co-operation with all the relevant parties.

6 Special issues

6.1 Consumption rooms and survival-oriented services in Switzerland

In Switzerland there are 12 consumption rooms, 10 of which include inhalation rooms. These were implemented as a reaction to the altered consumption habits of intravenous drug users. The consumption rooms are the first point of contact for drug users and offer hygienic facilities to inject drugs,

syringe/needle exchange, wound treatment, small-scale remunerated assignments, referral to other social and medical services, and psychosocial support for injecting drug users.

The aim is to support injecting drug users in the consumption rooms by encouraging self-care and to decrease risk behaviour related to drug consumption, in addition to dealing with other related health issues and fostering social integration.

Many of these goals have been achieved in the past 10 years. The visibility of drug use and its consequences in public have been reduced, delinquency has decreased and the health of injecting drug users has improved. The mortality rate of injecting drug users has dropped significantly. On the whole, social integration – in particular related to a stable living situation – has been achieved.

Rising numbers of service users in the past few years have meant a growing workload for the employees in the consumption rooms. Consequently, harm reduction, a task not limited to the provision of hygienic injection facilities but understood also in terms of psychosocial support, is restricted. At present closer surveillance and support of the various users is under review. Resources-oriented and individual-focused care appears to be a promising approach.

In addition, more than 200 harm-reduction facilities such as street work, night shelters and hostels, contact centres, work projects and halfway housing facilities, complete the range of harm-reduction services in survival support.

7 Strength and weaknesses

The great number and the high quality of institutions at each level are the strong points in Switzerland's treatment system. The influence and the professional exchange with countries such as Germany, France, the Netherlands and Anglo-Saxon countries have supported the development of the system. Most injecting drug users are in regular contact with the health system.

To co-ordinate three languages and different cultures in a small country challenges all the actors. If this is not working well, this can be a weak point. More then 50% of the injecting drug users are in a substitution programme. In most of the cases it is an advantage as people are in contact with the health system. Problems may occur when people stay on for an extremely long time in such programmes.

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Association for addiction – www.fachverbandsucht.ch

United Kingdom

1 Demography

The United Kingdom of Great Britain and Northern Ireland comprises four countries, namely England, Wales, Scotland and Northern Ireland. In 1999, some powers were devolved from the United Kingdom Parliament to Wales, Scotland and Northern Ireland. Devolution is, however, asymmetric, in that there are different levels of devolved responsibilities to each country. Only in Scotland is primary legislation possible, though only in some aspects; elsewhere such legislation remains the responsibility of the United Kingdom Parliament.

The population of the UK according to the 2001 UK Census was 58 789 184 with approximately 7.9% of the population from a minority ethnic group. England is the largest of these constituent countries, with just over 50% of the land area and 84% of the population.

2 Epidemiology of drug use

Overall use (not dependence or misuse) of illicit drugs by the UK population is estimated by the British Crime Survey (BCS). The British Crime Survey is a nationally representative survey of adults in England and Wales (but not Scotland or Northern Ireland) that includes questions on illicit drug use. The following are some of the key findings of the 2005/2006 survey:

- The 2005/2006 BCS estimates that 34.9% of 16-59 year-olds have used one or more illicit drugs in their lifetime, 10.5% used one or more illicit drugs in the last year and 6.3% in the last month.
- The survey also estimates that 13.9% of those aged 16-59 have used a Class A drug at least once in their lifetime, 3.4% used at least one Class A drug last year and 1.6% last month. (A Class A drug is a member of the most harmful group of drugs as decided by an expert panel – the Advisory Council on the Misuse of Drugs; this includes heroin, cocaine, crack cocaine, methamphetamine and ecstasy, but it does not include cannabis.)
- Cannabis is the drug most likely to be used. The 2005/2006 BCS indicates that 8.7% of 16-59 year olds reported using cannabis in the last year. Cocaine is the next most commonly used drug with 2.4% claiming to have used any form of it (either cocaine powder or crack cocaine) in the previous year. This is followed by ecstasy use at 1.6% and use of amphetamine at 1.3%. Amyl nitrite use in the last year is estimated at

1.2% and use of hallucinogens (LSD and magic mushrooms) at 1.1%. Other drugs are more rarely used.

– It is estimated that over 11 million people aged 16-59 in England and Wales have used illicit drugs in their lifetime while less than three and a half million are estimated to have used illicit drugs in the last year and approximately two million in the last month.
– It is also estimated that under four and a half million people aged 16-59 have used Class A drugs in their lifetime with over one million having used them in the past year and just over 500 000 in the last month.
– Between 1998 and 2005/2006 the use of any illicit drug in the last year decreased, reflecting a corresponding decline in cannabis use.
– Class A drug use in the past year among the 16-59 year olds increased between 1998 and 2005/2006. This is mainly due to a comparatively large increase in cocaine powder use between 1998 and 2000. However, between 2000 and 2005/2006 the use of Class A drugs overall remained stable. Between 1998 and 2005/2006 the use of LSD decreased.

2.1 Drug dependence and misuse

Latest estimates of problem drug use in England suggest that there are 332 090 heroin and crack cocaine misusers (a rate of 9.97 per 1 000 of the UK population). There are an estimated 286 566 problematic opiate users, 197 568 problematic crack users and 129 977 injecting drug users.

2.2 Prison

In 1997 more than 40% of male remand prisoners and 50% of female remand prisoners were estimated in the year prior to arrest as being dependent on opiates, cocaine (including crack form) or both.

2.3 HIV and hepatitis B/C

The prevalence of both HIV and hepatitis C is increasing in the UK. About 1 in 75 injecting drug users are infected with HIV although in London the figure is 1 in 20.

The prevalence of hepatitis C has increased from 33% in 2000 to 42% of injecting drug users in 2006. Approximately 1 in 5 injecting drug users has hepatitis B. The rate of hepatitis B in new injectors increased from 3.4% in 1997 to 10% in 2006. In 2006, 23% of injecting drug users reported needle sharing in the past month.

2.4 Drug-related deaths

Due to many factors including how deaths are recorded, consistency between coroners and difficulty in agreeing what constitutes a drug-related death,

there are difficulties in getting an accurate figure. The Office of National Statistics, using ICD-9 and ICD-10 codes from death certificates, estimates that there were 16 088 (12 687 male and 3 401 female) drug-related deaths (deaths involving drugs classified under the Misuse of Drugs Act) in the UK between 1993 and 2004. The median age of death for males was 32 years against 38 years for females. In 45% of cases drug abuse/dependence was described as the cause, accidental poisoning in 33% of cases, intentional self-poisoning in 11% and undetermined intent in 11%.

The number of deaths in 2004 related to drug misuse was 1 427. This showed a 9% decrease from 1999. There was, however, an increase in the number of deaths involving heroin/morphine and cocaine.

3 Short history of drug treatment

The UK has a long history of treating drug addiction that for many years was unique. This includes a long history of substitution therapy. A full description of the history of UK drug treatment is contained in *Heroin addiction and the British system*, edited by Michael Gossop and John Strang (2005).

More recently, prior to devolution, a United Kingdom Drug Strategy was launched in 1998, setting four principal aims:

– prevention of drug use amongst young people through education and prevention;
– safeguarding communities;
– expanding treatment provision;
– reducing availability through legal sanctions.

Following devolution, each country's administration produced its own strategy, reflecting the overarching UK drug strategy, but tailored to each constituent country's individual circumstances. This allowed each government to decide upon policy in areas where responsibility had been devolved, including health, education and social care; and, in the case of Scotland, policing and the criminal justice system, including all areas of offender management.

In England, the National Treatment Agency for Substance Misuse (NTA) was created in 2001 to oversee the added investment and the expansion of drug treatment in the UK with the aim of improving the quality of drug treatment in England.

In 2008, a new 10-year UK Drug Strategy *Drugs: protecting families and communities* was published, stating that drug treatment was the most cost-effective way to reduce drug demand. The provision of high quality and accessible drug treatment continued to be a priority, with matched government investment.

3.1 Availability and utilisation of drug treatment

In England, the numbers entering structured drug treatment increased from 85 000 in 1998 to 195 000 by 2006/2007. These statistics do not include those provided with drug treatment in prison. The average waiting time in England for drug treatment has been reduced from nine weeks in 2003 to less than two weeks in 2007. Over three quarters of new entrants to structured treatment are now retained for more than 12 weeks.

In England there are 149 local drug partnerships, which usually correspond to areas of local government. Each of these partnerships draws together a range of professionals including health, social care, housing and criminal justice. These local partnerships plan and commission local drug treatment systems, in line with *Models of care for treatment of adult drug misusers* (NTA, 2006) and other relevant guidance. Each partnership produces local drug treatment plans which are based on annual assessment of need. The NTA has a "delivery assurance" remit and NTA regional teams which scrutinise the delivery of local drug partnership annual treatment plans and resources. The NTA also works with health and social care inspectorate bodies to conduct annual themed reviews of drug treatment.

Monitoring of all those receiving structured care-planned drug treatment is carried out in England through the National Drug Treatment Monitoring System (NDTMS). This system gathers anonymous data on every drug user in treatment. In 2006/2007, just over 195 000 individuals were recorded as in contact with structured drug treatment services. The most frequently reported main drug of misuse by adults in treatment was heroin (66%), followed by 9% for methadone or other opiates, 12% for crack or cocaine and 7% for cannabis. For patients aged under 18 years-old, cannabis was the most frequent main drug of misuse (75%), with heroin or other opiates reported in 7% of cases and crack or cocaine in 6%.

In 2007 a new national outcome monitoring tool, the Treatment Outcome Profile (TOP) was validated and introduced. This is based on the Maudsley Addiction Profile (MAP). TOP data will be routinely collected on every client in structured treatment on a regular basis and is now part of NDTMS. This will allow the national monitoring systems to assess individual and drug treatment impact on client outcome on substance misuse, health, crime and social functioning.

4 Organisation of the treatment system

All drug treatment is delivered free of charge. Throughout most of the United Kingdom there is a four-tier system of treatment providing a conceptual framework for provision (NTA, 2006). Each of the 149 local drug partnerships in England is expected to commission local drug treatment

systems in line with this four-tiered framework to meet their unique local population needs:

– Tier 1 – these are generic services offering drug-related information and advice, screening and referral to more specialist services.

– Tier 2 – these are open-access interventions (such as drop-in services) providing drug-related advice and information and some harm-reduction interventions such as needle and syringe exchange.

– Tier 3 – this relates to structured or care-planned drug treatment normally provided by specialist community drug treatment services. This includes structured care planning and key working as core to all provision, prescribing interventions (including opioid stabilisation, opioid maintenance and reduction or detoxification programmes), structured day and other social programmes and structured psychosocial interventions (counselling, couple therapy, etc.).

– Tier 4 – these are inpatient and residential rehabilitation interventions for those who require more intensive drug treatment. Interventions can include detoxification for multiple dependencies, stabilisation, residential rehabilitation programmes and intervention for those with severe co-morbid mental and/or physical health problems.

5 Services

5.1 Community services

The majority of structured treatment is delivered at Tier 3, predominantly through community-based specialist drug treatment services. These specialist services are provided by a wide range of different organisations and professions depending on local need. The NHS, charitable sector and private sector provide services both in the community and residential settings. There are approximately 1500 community-based specialist drug services. It is increasingly expected that drug users will be provided with help to access a range of other services, including housing, education and employment.

Both general practitioners with special interest and psychiatrists with training in addictions are involved with providing these services. In Scotland, public health doctors have also been involved in its provision.

5.2 Inpatient services and residential rehabilitation

Inpatient and residential drug treatment comprise around 8% of drug treatment. Both stabilisation on substitution therapy and pharmacological detoxification is offered at inpatient detoxification units. Where relevant onward referral is made to residential rehabilitation units, the charitable

sector most commonly provides residential rehabilitation. There are three main residential rehabilitation treatment approaches:

1. Christian philosophy;
2. therapeutic community approach;
3. 12-step or Minnesota Model.

It is acknowledged that there is a shortage of inpatient facilities, particularly for residential rehabilitation. In 2007 the Department of Health announced that €79.7 million (£54.3 million) was to be made available for capital funding of inpatient and residential rehabilitation (Tier 4) in England over the next two years.

5.3 Criminal justice programmes

In England, the Drug Intervention Programme (DIP) was initiated in 2003 and focuses on areas with high levels of drug-related crime, using the criminal justice system as a route for getting drug misusers into treatment. Arrestees found to be drug users through testing on arrest are encouraged to enter treatment. Once sentenced, patients are encouraged to enter treatment through conditions attached to probation sentences. Drug rehabilitation requirements are treatment orders that give sentenced prisoners the option of entering a treatment programme instead of a standard sentence. As part of the programme, criminal justice intervention teams in each area manage the continuity of care provided to a drug misuser from the point of arrest through to sentence and beyond, including help with housing and education and training. More than 1000 drug-misusing offenders enter treatment each week in England.

5.4 Prisons

Prisons provide drug treatment services through a combination of prison services and the National Health Service (NHS). In England, offenders with drug problems receive detoxification (if required) and suitable short-term prisoners receive methadone maintenance. Drug-misusing prisoners also receive drug-related advice to reduce harm and prevent relapse, counselling and a limited number receive rehabilitative programmes. There has been an increase in resources to develop prison drug treatment in England with a focus on improving the quality of clinical drug treatment and also through care and interface with community drug treatment on release under the new Integrated Drug Treatment Service (IDTS) programme.

5.5 Clinical guidance

In 2007 the Department of Health published *Drug misuse and dependence: UK guidelines on clinical management*. These are considered the main

guidelines in drug treatment, setting the standards for treatment, especially regarding pharmacological interventions.

This guidance is supported and complimented by guidance from the National Institute for Health and Clinical Excellence (NICE). NICE covers all areas of medicine, producing guidance in the following forms:

– public health – guidance on the promotion of good health and the prevention of ill health;
– health technologies – guidance on the use of new and existing medicines, treatments and procedures within the NHS; if a treatment is approved by a NICE technology appraisal it has to be provided;
– clinical practice – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

In the treatment of drug dependence, NICE has also produced technology appraisals and two guidelines on drug misuse – "Drug misuse: psychosocial interventions" (NICE clinical guideline 51) and "Drug misuse: opioid detoxification" (NICE clinical guideline 52).

5.6 Dual diagnosis

Co-morbid mental illness and drug dependence is a considerable problem in the UK. The fundamental principle guiding treatment planning is that care for these individuals should be integrated, both into specialist addiction services and mental health services. Severe mental illness and addictions are handled by mental health services, while less severe disorders and addictions are handled by addiction services. The clinical guidelines on drug dependence mentioned above – *Drug misuse and dependence. UK guidelines on clinical management* – carry guidance on dual diagnosis; as do the above NICE guidelines.

The Department of Health has also produced the following further guidance:

1. "Dual diagnosis good practice guide" (2002);
2. "Dual diagnosis in mental health inpatient and day hospital settings" (2006).

5.7 Young people

The commissioning of services for young people across education, health and social care has in the past been fragmented. The advent of the 2004 Children Act and guidance published by the Department for Children, Schools and Families – "Every child matters" – has led to the creation of children's trusts co-ordinating the commissioning and provision of all services. It is expected that services will broadly work towards prevention, with targeted intervention where needed. *Every child matters: change for*

children – young people and drugs (DFES, 2005) described drug treatment for young people falling into three categories:

– universal provision – for all young people;
– targeted provision – for those groups most at risk;
– specialist substance misuse treatment provision.

All partnerships should be commissioning services that fit within this framework.

6 Special issues

Drug treatment in the UK has undergone a massive expansion over the past 10 years. This has been a consequence of many factors including increased recognition of the harm caused by illicit drugs both to individuals and society, increased drug use, and a greater understanding of treatment and its benefits. This increased drug use has stabilised over recent years, but there continues to be an increase in the use of cocaine.

As a consequence of the increased investment in drug treatment there has been a drive to standardise treatment and improve quality of care. This has led to development of guidance and greater regulation.

7 References

British Crime Survey – www.homeoffice.gov.uk/rds/pdfs06/hosb1506.pdf
Clinical management of drug dependence in the adult prison setting – www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063064
Commissioning young people's specialist substance misuse treatment services – www.nta.nhs.uk/commissioning-young-peoples-specialist.aspx
Drug interventions programme guidance – http://drugs.homeoffice.gov.uk/drug-interventions-programme/guidance/
Drug misuse and dependence: UK guidelines on clinical management – www.nta.nhs.uk/publications/documents/clinical_guidelines_2007.pdf
Drug misuse: methadone and buprenorphine – www.nice.org.uk/guidance/index.jsp?action=byID&o=11606
Drug misuse: naltrexone – www.nice.org.uk/guidance/index.jsp?action=byID&o=11604
Drug misuse: opioid detoxification – www.nice.org.uk/guidance/index.jsp?action=byID&o=11813
Drug misuse: psychosocial interventions – www.nice.org.uk/guidance/index.jsp?action=byID&o=11812
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Dual diagnosis in mental health inpatient and day hospital settings – www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_062649
Every child matters change for children: young people and drugs – www.everychildmatters.gov.uk/
Home Office: Drugs; protecting families and communities– http://drugs.homeoffice.gov.uk/publication-search/drug-strategy/drug-strategy-2008-2018?view=Binary
IDTS guidance – www.nta.nhs.uk/areas/criminal_justice/idts_faqs.aspx
Models of care for treatment of adult drug misusers, NTA, 2006 – www.nta.nhs.uk/publications/documents/nta_modelsofcare_update_2006_moc3.pdf
Models of residential rehabilitation for drug and alcohol misusers – www.emcdda.europa.eu/.../att_101801_EN_7.%20UK07_residential_rehab.pdf
National and regional estimates of the prevalence of opiate use and/or crack cocaine use 2005/06: a summary of key findings – www.homeoffice.gov.uk/rds/pdfs07/rdsolr2107.pdf
Psychiatric morbidity among prisoners – www.statistics.gov.uk/downloads/theme_health/Prisoners_PsycMorb.pdf
Trends in deaths related to drug misuse in England and Wales, 1993-2004. Office for National Statistics – www.statistics.gov.uk/downloads/theme_health/HSQ31.pdf
Unlinked anonymous survey of injecting drug users. Health Protection Agency – www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1202115519183

Links to drug treatment planning in Scotland and Northern Ireland

Drug misuse information Scotland – www.drugmisuse.isdscotland.org
Northern Ireland Assembly's website on drugs and drug strategy – www.healthpromotionagency.org.uk/Work/Drugs/menu.htm

South of Europe

Cyprus

1 Demography

Cyprus is the third largest island in the Mediterranean (after Sicily and Sardinia), with an area of 9 251 square kilometres. It is situated at the north-eastern end of the Mediterranean basin, at the crossroads of Europe, Africa and Asia.

Administratively, Cyprus is divided into six districts. These are Nicosia, Limassol, Larnaca, Paphos (in the government-controlled areas) and Kyrenia and Famagusta (in the occupied areas). The island's capital is Nicosia, with a population of 180 000 including suburbs.

The official population of the island is 850 300 (December 2005), of which approximately 76.8% are Greek Cypriots (this figure includes the 8 000 (1%) Maronites, Armenians and Roman Catholics who opted to join the Greek Cypriot community according to the provisions of the 1960 Constitution), 10.3% are Turkish Cypriots and 12.9% are foreign residents and workers. Greek and Turkish are the official languages. Cyprus has been a member of the EU since 1 May 2004 (Ministry of Foreign Affairs of the Republic of Cyprus).

2. Epidemiology of drug use

Information on the prevalence of drug use in the general population allows for a conservative estimate of the extent of the drug problem in Cyprus by converting the prevalence reported in national surveys into the number of drug experienced individuals among all inhabitants aged 15-64.

In Cyprus there are two nationwide surveys to explore the prevalence of drug use in the general population. The most recent general population survey was conducted in 2006 among 3 504 people between the ages of 15 and 65 (Cyprus Anti-Drugs Council, 2006). The results of the survey are presented in Table 12 below.

Table 12: Prevalence of illicit drug use in Cyprus (Haasen et al., 2007)

Sample: 3 504	Cannabis	Ecstasy	Amphetamine	Cocaine	Heroin
Lifetime prevalence (%)	6.6	1.6	0.9	1.2	0.9
Last year prevalence (%)	2.1	1.0	0.4	0.6	0.4
Last month prevalence (%)	1.4	0.6	0.3	0.4	0.3

In Cyprus, cannabis is the most widespread illicit substance ever used by adults. However, the lifetime prevalence for cannabis use in Cyprus is one of the lowest in Europe (EMCDDA, 2006). Last year prevalence of cannabis use was reported to be 2.1%, and for last month prevalence of cannabis use (1.4%), Cyprus lies in the middle of the European ranking table as the prevalence rates range from 0.8% (Sweden and Bulgaria) to 7.6% (Spain).

The lifetime prevalence of amphetamine and cocaine use is quite low compared to other European countries.

While the lifetime prevalence of illicit drug use among the general population in Cyprus is comparably low, this is quite the opposite with regard to the last month prevalence rate. In the last 30 days, 1.4% of the population reported cannabis use which is still rather low compared to other countries. However, the last month prevalence figures reported for amphetamine, cocaine and in particular for ecstasy are considerably higher in comparison to other countries, as only a few of these are above this percentage. In the last month, 0.3% of the general population in Cyprus used amphetamine and only six out of 28 countries show a higher percentage. In particular, the last month use of ecstasy is at the top of the European ranking table. Of all European countries, the last month prevalence rate for ecstasy use in Cyprus is only topped by the United Kingdom and the Czech Republic with a prevalence estimate of about 1% (EMCDDA, 2006).

On the basis of the last month prevalence estimate among the general population, for the 15-64 age-group, it can be ascertained that in Cyprus, about:

– 7 495 people are current cannabis users;
– 1 598 are current heroin users; and
– 2 131 people are current cocaine users.

For the period 2004-2007 there were 64 drug-related deaths registered. In particular, in 2006 there were 17 deaths mainly of men, aged 20-24, related to overdoses caused by a combination of substances, including opiates.

With regard to high-risk drug-use patterns, a major concern is that related to needle-sharing behaviour. Intravenous use is the main administration route among heroin users in treatment and the most recent report of the Cyprus National Focal Point noted an increase in drug users sharing needles from 12.5% in 2004, to 14.7% in 2005 (Reitox National Focal Point Cyprus, 2005).

There is no reliable evidence on the prevalence of blood-borne viruses, for example HIV and hepatitis, amongst injecting drug users in Cyprus. This is due to the fact that the data available only relates to tested clients in treatment and many clients have not been tested at all. In 2006, 30% of injecting drug users that were tested were found to be positive for hepatitis B and C (Reitox National Focal Point Cyprus, 2007).

3 Short history of drug treatment

With regard to the development of drug services, it could be said that the first services started to operate in the early 1990s, such as, for instance, the outpatient service Promitheas, and the inpatient service Themea. However, many of the services have readjusted their mission and target group since their operation, while others have started to offer their services more recently during the last three to five years.

Currently, there are 20 treatment units, located mainly in the capital Nicosia, but some units are also located in Limassol, Larnaka and Paphos. Most of the drug treatment services are non-governmental organisations. Six of the current drug services are governmental and co-ordinated and monitored by the mental health services, under the Ministry of Health. There are also two treatment units Stochos and Toxotis operating on a collaborative basis between the public and private sector. All treatment programmes are co-ordinated by the Cyprus Anti-Drugs Council.

The types of treatment offered in Cyprus include counselling, motivational enhancement therapy, as well as more intensive rehabilitation treatment programmes. Treatment also includes medical treatment (detoxification) and harm-reduction practices, including substitution treatment.

The services offered in the field of treatment cover not only drug dependent cases but also cases of less systematic drug use. Drug services are currently differentiated in three broad categories: “outpatient treatment”, “inpatient treatment” and “counselling”.

As regards the cultural context of treatment offered in Cyprus, it is important to mention the significance attributed to the role of the family. The family is actively involved in assisting and supporting the treatment process. The approach to treatment favoured so far is psychotherapeutic abstinence-based treatment in an inpatient setting. Yet, a change in approach has been adopted lately whereby efforts are being made to increase the availability of treatment options. Substitution treatment has been introduced and there is a trend towards the availability of more outpatient treatment programmes.

4 Organisation of treatment services

Since 1 May 2004 Cyprus has become a full member of the EU. With regard to the drug issue, the process leading to full integration required the adoption and implementation of the European Drugs Strategy. Accordingly, the Law on the Prevention of the Use and Dissemination of Narcotic Drugs and Other Addictive Substances was enacted in 2000, which provided for the establishment of the Cyprus Anti-Drugs Council (CAC). Specific regulations within the aforementioned law also provided for the creation of the Cyprus Monitoring Centre for Drugs and Drug Addiction (EKTEPN).

The CAC falls under the responsibility of the Ministry of Health and is financed by this same ministry. The CAC is the supreme co-ordinating body in the field of addictive substances, both legal and illegal, and is thus responsible for the co-ordination of governmental as well as non-governmental addiction services.

By law, the CAC was established with the aim of creating an organisation for the implementation, co-ordination and monitoring of the Cyprus National Drugs Strategy. The CAC consists of a board of nine members and an executive secretariat. According to legal requirements, the members of the CAC are appointed by the Ministerial Council for a period of three years. In detail, the CAC is chaired by the Minister of Health who fulfils the function of president of the CAC. The chairperson of the Cyprus Youth Board plays a role as vice-president. In addition, seven experts are appointed as members of the board. Their nomination is based upon their scientific training and/or specialised knowledge or activities in connection with prevention, treatment or rehabilitation of addicted persons.

The CAC has the following competencies and functions:

- it acts as a liaison between the Republic of Cyprus and organisations abroad regarding the transmission of information on addictive substances;
- it develops and implements the National Drugs Strategy and the National Action Plan on Drugs, aligned with the EU Drugs Strategy;
- it undertakes the strategic planning of national drug policy and promotes, monitors and controls its implementation;
- it encourages, promotes, co-ordinates, monitors and evaluates drug treatment and prevention programmes in the public and private sectors;
- it also has overall responsibility for the establishment, support and monitoring of the Reitox National Focal Point (EKTEPN) (Cyprus Anti-Drugs Council, 2004).

Professionals working in treatment services consist of:

- psychiatric nurses: they have an active role in treatment and some of them have gained expertise as addiction counsellors;
- psychologists: the majority of treatment units are staffed by a psychologist, usually working on a full-time basis;
- psychiatrists: some treatment settings have a psychiatrist working full time while other settings refer patients to a psychiatrist for an assessment or further psychiatric care;
- occupational therapists: this is a new professional group in Cyprus and specific training to gain qualifications and attitudes in the field of drug treatment is considered as necessary;

- art therapist/drama therapist/dance therapist: some treatment programmes are staffed by these professionals, usually on a part-time basis;
- counsellors: specialised in drug addiction;
- social workers: social workers also work in this treatment field, yet the significance of their role has not been broadly established.

It should be stated that at present there is a lack of uniformity in the system regarding professional requirements related to the addiction field.

5 Services

5.1 Detoxification

Since 2004, three different services have been available for detoxification. The most recently established non-governmental facility, the Veresies Clinic in Larnaka, started with buprenorphine treatment for detoxification. It provides inpatient as well as outpatient treatment. In addition, with regard to public services, Anosis, which is located in Limassol, offers inpatient medically assisted detoxification to users of illicit drugs. The inpatient detoxification unit Themea provides treatment for legal substances.

5.2 Evaluation/planning of treatment

Every treatment service is responsible for the evaluation and planning of treatment, usually provided by the multidisciplinary team consisting, for example, of psychiatric nurses, psychiatrist and psychologist.

5.3 Treatment

5.3.1 Substitution treatment

Until recently, Cyprus was the only EU member state not offering substitution treatment. However, in the summer of 2007 the first opiate substitution treatment programme Gefira was launched in Nicosia. Substitution treatment is now also offered in Limassol. The substitution substance used is buprenorphine. Approximately 50 opiate users, with a long history of failed attempts to abstain from their drug use, participate in the programme.

5.3.2 Drug-free treatment services

As has already been stated, abstinence-based treatment is the most prominent approach in Cyprus. Overall, there are 11 drug-free services covering all geographical areas of the island.

First of all, counselling centres constitute the first step in the treatment process. Eight counselling centres exist, with at least one in each major city in Cyprus. Two of these centres are governmental.

Pyxida is located within the capital's region and is a public service. It offers treatment programmes to dependent adults and their families. These programmes can either be inpatient or outpatient. The centre's therapeutic approach is based mainly on the philosophy of therapeutic communities.

"Ayia Skepi" is a non-governmental service located within the Nicosia region. It is a long-term residential therapeutic community for adult drug addicts aged between 18 and 40.

"Tolmi" is a non-governmental outpatient programme which lasts approximately 12 months. It operates in four big cities. It offers individual and group therapy to adult users of legal and illegal substances and their families.

5.3.3 Dual diagnosis treatment

A service designed specifically for treating dual diagnosis is not available in Cyprus. Some treatment services do not accept patients with co-morbidity while others do not specify this issue in their admission criteria.

5.3.4 In/outpatient

Four inpatient treatment services exist, two governmental: Anosis and Pyxida and two non-governmental: Ayia Skepi and the Veresies Clinic.

All other treatment units provide outpatient psychosocial interventions. The main function of the eight existing counselling centres is to prepare drug users for further treatment by means of motivation enhancement, and then to refer them to detoxification and/or inpatient drug treatment. In addition, there is the non-governmental organisation "Tolmi" which operates outpatient therapeutic communities in four towns. The outpatient therapeutic community is designed for drug users of all ages and offers a 12-month treatment programme.

As already mentioned above the drug facility Pyxida also provides outpatient drug treatment programmes, one directed at preparation for intake into the inpatient therapeutic community, the other addressed to drug users who are in need of outpatient psychosocial interventions.

Last but not least there is the drop-in centre Stochos which offers harm-reduction services, such as safe use practices, food and blood tests and will soon provide needle exchange practices.

5.3.5 Drug and/or alcohol and prescribed drugs

Outpatient facilities offer treatment for drug and/or alcohol and prescribed drugs, whereas inpatient facilities focus exclusively on illicit drugs.

5.3.6 Availability/link to somatic and psychiatric treatment

In most treatment settings, availability to somatic and psychiatric treatment is offered on an outpatient basis (referrals).

5.3.7 Rehabilitation services linked to treatment

Social integration programmes for illicit drug users are provided by three treatment services:

- Pyxida: after staying four months in the inpatient programme, members are supported in finding a job or housing;
- Ayia Skepi: during the last six months the patients are offered a social integration programme, a relapse prevention programme and vocational support;
- Tolmi: for six months, interests, abilities and skills are enhanced in order to help members find a job.

The above treatment centres collaborate and encourage participation in the following national schemes that promote reintegration:

- the scheme for financial support for the social reintegration of former dependent persons, concerning housing, education and professional training, which was implemented by the social welfare services and the Ministry of Labour and Social Insurance;
- the Cyprus Productivity Centre, which is a public service and operates under the Ministry of Labour and Social Insurance, aiming to teaching skills in different professional sectors, through fast-learning programmes;
- the Human Resource Development Authority of Cyprus which aims to create the necessary prerequisites for the planned and systematic training and development of Cyprus' human resources, at all levels and in all sectors, including drug users.

5.3.8 Treatment of young people

Two public services offer open short-term and long-term programmes for adolescents and their families: Perseas which is situated in the capital city and Promitheas in Limassol.

These brief intervention programmes are intended for:

- experimental and occasional users aged 12-22;
- parents/families of adolescents and young occasional and experimental users.

The duration of the programme ranges from six to nine months for the short-term programme and from 12 to 18 months for the long-term programme.

As regards young people, there is still no specific treatment programme that caters for the needs of problematic drug users.

5.4 Gender issues

First of all, the treatment data show that the vast majority of all treatment clients are male. Only 13.5% of the clients are women. Even though there is no information on the gender relation of the problem drug users, it can be assumed that in Cyprus more than 13-15% of the problem drug users are women. This presumption is supported by the fact that there is a noticeable increase in young female drug users aged 15-19 demanding treatment for the first time. According to the most recent report, the proportion of first treatment requests by young women increased from 17% in 2003 to 36.8% in 2005 (Reitox National Focal Point Cyprus, 2006). However, despite this increase, women seem, in general, not to be much attracted to the current drug services.

An NGO has planned to establish a residential treatment unit exclusively designed for women drug users. This centre will be located in Nicosia and will offer traditional inpatient drug treatment, with an emphasis on maintaining long-term recovery. This inpatient facility will also provide prenatal care for pregnant women addicts, a mother-child programme and a mechanism by which children in foster care can be reunited with their mothers.

5.5 Treatment within the criminal system

Currently, within the prison system the only treatment programme provided is a psychological rehabilitation programme. It is provided in four phases:

1. evaluation;
2. closed psycho-educational group;
3. closed therapy groups on specialised topics (such as expression groups, anger management groups, working and social skills groups); and
4. re-evaluation-closing (additionally, detoxification is provided within the context of an outpatient service).

There are no substitution treatment programme or harm-reduction measures available in prison.

6 Special issues

Even though professionals from drug treatment services have pointed out that migrants constitute a significant group among the treatment clients, there has been no systematic documentation or findings regarding this population's drug use and their needs.

7 Strengths and weaknesses

The above record and description of the therapeutic continuum in the field of drug addiction in Cyprus identifies a number of weaknesses:

– harm-reduction measures: with regard to substitution treatment, which constitutes an important aspect of the harm-reduction programmes, the Ministry of Health has initiated the operation of the programme recently but there are no other harm-reduction services aiming at prevention and care offered as yet, such as needle-exchange programmes, outreach programmes or vaccinations.

– intensive day-care programme for addicted adolescents: the Ministry of Health is set to start providing an intensive day-care programme for addicted adolescents in 2008 and this will operate on a daily basis without overnight stays and weekends and will be intended for adolescents dependent on heroin;

– intensive outpatient treatment programmes for adults: despite the fact that there are a multitude of treatment options on offer, there is nevertheless no outpatient intensive treatment programme for problematic users, whereby an individual can benefit from a comprehensive intervention on a daily basis which usually includes regular contact with the programme and participation in treatment procedures, as well as other types of activity;

– co-morbidity programmes and programmes for dependent women: in Cyprus there is a lack of specialised programmes aiming to cater for the needs of people with drug addiction problems and mental disorders, as well as programmes tailor-made for dependent women;

– treatment programmes for cocaine addicts: as in many other European countries, a treatment programme specifically designed to address cocaine use does not exist in Cyprus;

– professional requirements: as has already been stated, there is a lack of a common system regarding professional requirements in the addiction field.

However, it should be stated that since the establishment of the Cyprus Anti-drugs Council, the co-ordination of treatment services is steadily improving. Also, due to the island's small size and the number of programmes available, the co-ordination of the treatment system is not as complex as in many other countries.

In conclusion, the drug treatment system in Cyprus needs to be improved by establishing a further diversification of the treatment options and by integrating specific treatment offers into the existing drug services.

8 References

8.1 Websites

www.agiaskepi.org – "Ayia Skepi" Treatment Programme and Counselling Station
www.ask.org.cy – Cyprus Anti-Drugs Council
www.ektepn.org.cy – Reitox National Focal Point
www.kenthea.org.cy – Kenthea Cyprus
www.mfa.gov.cy – Ministry of Foreign Affairs
www.moh.gov.cy – Ministry of Health
www.veresies.com – Veresies Clinic

8.2 Organisations

Anosi Detoxification Unit
Ayia Skepi Treatment Programme and Counselling Station
Cyprus Anti-Drugs Council
EKTEPN
Fos Kenthea Counselling Station
Iraklis Kenthea Counselling Station
Ithak Kenthea Counselling Station
Odysseas Kenthea Counselling Station
Pegasus Kenthea Counselling Station
Perseas Adolescent and Family Counselling Centre
Promitheas Drug Prevention and Counselling Centre for Adolescents and Families
Pyxida Treatment Programme
Stohos Day Care Centre
Tolmi Open Therapeutic Community for Addicted Persons (Nicosia, Larnaca, Limassol, Pafos)
Toxotis Counselling Station
Vera Paisi Kenthea Counselling Station
Veresies Clinic

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Italy

1 Demography

1.1 Characteristics of the population

Italy is subdivided into 20 regions, 109 provinces and 8 101 municipalities; in the last quarter of 2006 the population was estimated to be approximately 59 million, roughly 400 000 more than the previous year. This increase is almost exclusively due to migratory movement, since natural movement remained at nearly zero level. These migratory flows, that are more recent and rapid in respect to the other EU nations, have brought the foreign population regularly resident in Italy to almost three million (5% of the total population, in contrast to 2.7% in 2003), to which must be added an estimated one million "irregular" residents.

These flows are fundamental also at an economic level, considering that Italy is one of the European nations with the highest number of pensioners (71 for every 100 working adults) and with the highest pension expenditure: approximately €215 billion annually, equal to 15% of the country's gross national product (GNP). On the one hand, better living conditions, greater attention to prevention and progress in the health field have resulted in a life expectancy near the top of the world classification: 78 years for men and 84 years for women. On the other hand, low birth rates (1.35 children per woman) make Italy one of the "oldest" countries in Europe, with 141 people over 65 years of age for every 100 aged under 15. What is more, old-age indexes have repercussions on family income: 11% of Italian families live below poverty level and half of these have a member over 65 years of age. The net income per family averages around €2 750 monthly, but this figure is subject to significant variations in relation to the territory and the breadwinner's gender. The income of families in southern Italy and that of families where the principal earnings derive from a woman's work are on average one third less than the income of a family in northern Italy or of a family where the major earnings are produced by a man. In this context, the structure of the family is also changing: in the last 40 years the average number of members has dropped from 3.6 to 2.6 per nucleus.

1.2 Social and health care costs

There are therefore various macro-phenomena which need evaluation in terms of welfare programming and in relation to the present context of low economic growth: the progressive ageing of the population, the increase in resident foreigners, the progressive disparity between the north and

the south of the country and (a possible consequence of these factors) the emergence of new forms of poverty.

The state budget areas most affected by these transformations are social services and health services expenditures. The first absorbs 0.4% of the GNP, is 75% managed by the municipalities and shows noticeable disparities between north and south in terms of per capita allocation; the second, almost entirely managed by the regions, absorbs approximately 8.7% of the GNP in spite of a ceiling fixed at 7%. Health service expenditures show a less marked differentiation between north and south, partially because the attribution to the regions of greater management responsibility in this sector is quite recent. A WHO study placed the Italian national health system among the top in the world for capacity and quality of assistance, a judgment confirmed by European surveys on satisfaction as expressed by the public (75% of Italians are satisfied with public health services). Behind a system which guarantees homogeneous levels of assistance over the entire territory and fair access for all citizens, there lies a considerable financial commitment, which increased from €48 billion in 1995 to €92 billion in 2005. National health expenditure (approximately €1 600 per capita) represents 13.7% of the nation's entire budget; only 25% of health care costs are paid by the citizens themselves.

Within the 15 European Union nations at the time of these statistics, Italy ranked first in the number of doctors per capita (3.8 per 1 000 inhabitants) but near the bottom in the number of nurses (7 per 1 000 inhabitants. Italy also ranked near the top in the number of hospital beds (3.3 beds per 1 000 inhabitants), although a progressive rationalisation has reduced this number (4.2 per 1 000 in 2003) in favour of increased domiciliary assistance (from 551 persons per 1 000 inhabitants with home assistance in 2003 to 679 per 1 000 in 2005).

2 Epidemiology of drug use

2.1 Trends in the consumption of psychoactive substances

It would seem that only illicit substances are not being affected by the present generalised reduction in consumption trends. The increased quantities of illegal psychoactive substances available on the market and the concomitant reduction in their prices have created a progressive growth in the consumption of all such substances during recent years. Sample surveys conducted nationally every year by the CNR (National Research Council) register in particular an increase in the simultaneous consumption of various substances: 82% of cocaine users and 45% of heroin users declare an associated use of other substances; only cannabinoids users maintain an "exclusivity" of substance (89% of cases).

Cannabis use shows one of the most consistent increases among 15-54 year-olds: from consumption at least once in last year by 6.2% of the population in 2001 to 14% in 2007. The most significant increases are to be found among those aged between 25 and 34 years of age, where female and male referring cannabis consumption in the last year increased by 40% and 50% from 2005 to 2007. Among the school population, the growth trend for this consumption is lower, but the absolute percentages are a great deal higher: 23% of students declare that they have consumed cannabinoids in the preceding year. However, it is in the use of cocaine that Italy registers one of the highest consumption levels in Europe: with 2.2% of the population having taken this substance during the preceding year, Italy ranks third after Spain (3%) and the United Kingdom (2.4%). The fact that "only" 15% of these users have taken cocaine more than 20 times during the preceding year would seem to indicate a prevalence of occasional use, but the risks involved in even sporadic use mean that the phenomenon should not be underestimated. Heroin, used by 0.3% of the population during the preceding year, shows a pattern similar to cocaine, characterised by the stabilisation of habitual consumption and a slight growth in occasional use; different from cocaine, however, occasional use represents only 60% of consumption. For both cocaine and heroin, the most worrying 2007 data refer to the school population: of the 4.2% using cocaine and the 1.4% using heroin during the preceding year, 14% of the former and 22% of the latter can be classified as problematic consumption (more than 20 times per year). Regarding synthetic stimulants, Italy has a history of consumption inferior to levels in other European countries. However, the increase registered in recent years (particularly among the young) would seem to indicate an inversion of the trend. In the 15-19 age range, consumption at least once in a lifetime grew from 2.3% in 2002 to 4.7% in 2007.

The huge increase in synthetic drugs confiscated in 2007 (+195% compared to 2006, with peaks of +900% in some regions) would seem to confirm a significant growth in substance use above all on the part of youngsters and in recreational contexts. In a trend counter to that of the general public, the school population shows an increase in alcohol consumption from 64.7% in 2000 to 69.6% in 2006. Specifically there can be seen the spread of the consumption pattern called "binge drinking", especially dangerous for health and correlated risks, above all because alcohol abuse is often associated with psychoactive substance use.

2.2 Correlate pathologies and mortality

The spread of new substances and new consumption styles renders it more difficult to estimate health damage and associated mortality. There is a need for new shared parameters in order to evaluate the relationship between the consumption of these substances and various lethal or at least debilitating

situations (accidents, violent acts, infections, pathologies of a cardiac, respiratory or neurological nature, etc.). As regards mortality, the only data available are those regarding death by overdose and acute intoxication: in Italy (after a peak in 1996 of 1 556 deaths), these have stabilised at about 500/600 cases annually since 2003. However, there has been a significant increase in deaths associated with cocaine consumption, rising from 2% to 9% of the total in the period 2001-2006. Although these partial statistics may seem alarming, they do need to be redimensioned in relation to a population with an estimated 24 000 alcohol-associated and 80 000 tobacco-related deaths annually.

Let us now consider infective pathologies related to drug use. Since the beginning of the Aids epidemic, Italy has registered 58 400 cases, with 35 300 deaths. After the 1995 epidemic peak of 5 600 registered cases, the situation has settled at about 1 200 cases annually. This result has been achieved above all thanks to the effects of combined antiretroviral therapy, which has led to an increase in Aids-diagnosed subjects still living, now estimated at over 23 000.

More or less the same situation exists for HIV-positive people (among which the Aids-infected are included), estimated at 120 000. This number tends to increase slightly, since 3 500/4 000 new infections are registered annually and these generally go into statistics for infections acquired in previous years: the higher survival rate of HIV-positive people results in an increase in the number of infected people on a national level.

The data reveal a change in the characteristics of HIV-positive and Aids-infected people. The decade from 1997-2007 shows a decrease in drug addicts (from 58.1% to 27.4%), while there is an increase in the people infected by sexual means, whether heterosexual (from 20.7% to 43.7%) or homo/bisexual (from 15% to 22%). The age of infected people is higher: in the case of Aids it is now on average above 40 years. It must be underlined that more than 60% of Aids cases arise in persons who have not undergone antiretroviral therapy prior to diagnosis. This is primarily due to the fact that more and more individuals (over 50%) realise they are HIV-positive only once the diagnosis has been ascertained. This phenomenon represents a clear signal of low perception of risk, especially for those whose infection is sexually-transmitted and for foreigners.

Mortality rates follow the peak of 1995 (4 581 deaths due to Aids), but as of 1997 there has been a progressive decrease, ending in an estimated 200 for the year 2007. This significant diminution in mortality is a direct consequence of the progressive insertion of new antiretroviral therapies that have contributed to transforming Aids into a chronic condition. Of those with HIV 30% have a co-infection of hepatitis C, a virus that is estimated to involve 1.5 million people, with thousands of new cases yearly. The estimates

for hepatitis B are slightly lower: 900 000 people, of whom one third have developed the chronic form.

3 Short history of drug treatment

In Italy, as in the most western countries, the history of pathological addiction treatment has been for many years the history of heroin addiction. The massive spread of this substance, which started at the end of the 1970s, focused technical and political attention on the procedures for facing a seeming epidemic. In this context, the first two identified preferential ways of treatment were methadone and therapeutic communities. As often happens without scientific evidence, however, for a long time the evaluation of these instruments' usefulness was affected more by ideological and cultural factors than by technical or scientific considerations.

Particularly in relation to methadone, there has been a protracted and polarised discussion between those considering it the essential element of treatment for a heroin addict and those seeing it as a danger bigger than heroin itself, defining it in the end as a "state drug". In the early period, the public services were accused of being simple methadone distributors but treatment then moved to a period of experimentation with drug-free treatment, characterised by the absence of pharmacological therapies. This experimentation was allowed through an approach between public services and structures managed by NGOs, and by overcoming cultural barriers and disagreements based on the need to maximise the potential of the addiction intervention system.

In this process, endogenous and exogenous factors, such as the services system and the scientific community, have come into play. On the one hand, the increase in the number of studies on heroin addiction characteristics and kinetics supported the utility of methadone therapy, particularly when integrated with psychosocial courses. On the other hand, the spread of the Aids virus at the end of 1980s added a health perspective to risk reduction, which is still central to addiction treatment and has been progressively extended to the patients' social and relational dimension. The debate on the use of methadone has now moved on, thanks in the main to access to international scientific literature. So its dosage and the right treatment duration could now be based on aims linked not only to liberation from the substance, but also to the improvement of people's total quality of life. The reality in distinguishing the needs and aims that are realistically achievable by each patient has also determined the variety of residential interventions which, like methadone at the beginning, were considered sufficient and decisive as regards addiction treatment.

The history of therapeutic and rehabilitating interventions carried out in residential structures for illicit drug users in Italy had a particularly peculiar

development in comparison with most other western countries. Indeed, from the second half of the 1970s, the widespread presence of communities inspired by the US models, such as Daytop, or by the professional models of United Kingdom psychiatric services, has been supported almost exclusively by voluntary services and NGO forces. From the second half of the 1980s and for the next 10 years, these structures were, for the non-professional as for many opinion leaders, both professional and political, the main way through which drug addiction could be treated. As a result, these structures proliferated and, despite differences in content and aims, by the middle of the 1990s there were more than a thousand places in these therapeutic communities. During these years, however, it was noticed that a great number of patients relapsed and this caused a crisis in the therapeutic community model, resulting in the closure of many institutions and the reorganisation of those that survived. This reorganisation concerned mostly a reduction in the duration of residential treatment and the setting up of programmes for socio-educational and psychological support, to guarantee continuity between inpatient and outpatient programmes.

Treatment of drug addiction thus evolved with the increase in knowledge and understanding that addiction to substances is a relapsing chronic pathology and in the main cannot be cured with single decisive interventions. It requires medium- or long-term treatment, in which the therapeutic aspects blend with those relating to rehabilitation and risk reduction.

3.1 The most recent evolutions

While the two preferred ways for heroin addiction treatment – detoxification and maintenance – were deeply rooted in the Italian community, new forms of addiction required a rethink of the theoretical and practical reference model. The spread of drugs such as cocaine and psychostimulants, but also of addictions not connected with specific substances, for instance gambling, modified people's reactions. It moved from the realm of deviance to the realm of normality, where consumption no longer represents a total experience, but becomes one of life's components. There are no social groups immune to the risk of becoming addicted and, particularly among young people, drugs appear to be an unavoidable ritual. In summary, the ability to distinguish between consumption, misuse and addiction becomes central, not because they are completely different phenomena, but because they are possible transitions of the same problematic evolution.

The main effects of this recent change have been observed, in particular, in preventive interventions in schools and other places where young people meet, in the specialisation of psychosocial interventions and in the improvement of professionals' diagnostic competencies. The latter are required to discern not only the patterns of drug intake, but also its problematic nature as regards individual life. Then there is another implicit factor in this

evolution, which is the ever more frequent co-occurrence of abuse of substances and personality disorders. Avoiding the clearly restrictive definition of dual diagnosis or the debate about the causal relationship between the two components, it is evident that the addition of psychological problems obliged Italian addiction services to extend their intervention focus and to acquire ever more specialist competencies in the psychotherapeutic and psychiatric fields.

The historical evolution of treatment has to be analysed from a scientific, cultural and institutional point of view. The fact that the consumption of legal or illegal substances and different forms of compulsive behaviour are permeating contemporary society not only caused an internal reorganisation of addiction services, but also changed the whole arrangement of the national health system, where an ever greater importance was attached to regional services.

4 Organisation of treatment services

4.1 The reference framework

In Italy the distribution of treatment for people with problems of pathological addiction is almost completely under the charge of the national health system (Servizio Sanitario Nazionale – SSN) and depends on the appropriate fund set aside by the Ministry of Health, absorbing about 0.7%. Then there are other, but more limited, funds, such as the one distributed by the Ministry of Welfare through a generic fund for social politics, mostly destined for preventive and rehabilitation projects, and that distributed by the Ministry of Justice for treatment of addicted inmates.

The SSN allocates to regions a share of this fund according to the number of resident people, thus limiting resources available, which in many areas are often and abundantly overspent. Regions, in turn, distribute the funds to the individual local health service agencies (ASLs), which provide services through several departments, including those for pathological addictions (as opposed to psychiatric ones), and to specific operational units which provide drug addiction services (servizi tossicodipendenze – SerT) established by Law No. 162/90. Whereas the guidelines are defined at national level through different legislation (Law Nos. 685/75 and 229/99), it is up to the regions, through specific decisions and the drawing up of a regional health plan, to put them into practice within their jurisdiction, allocating finance to the ASL budgets in relation to forecast activity.

Due to the way that addiction services are organised, treatment is offered within many different local and regional structures, but not by hospitals. Indeed it is curious, and in some ways indicative of the general perception

of the phenomenon, that there are no specific university courses on this topic, either in medical schools or, with only two exceptions, in psychology faculties.

4.2 Addiction department activity

Regional autonomy was strengthened under the 2001 Constitutional Law, which gives them specific powers for departmental organisation and is now resulting in some structural differences. But there are several central functions which unite the Italian pathological addictions departments: co-ordinating the operational units in the diagnosis, treatment and outcome assessment processes; investigating the needs of the population; increasing accessibility and speed of treatment; assuring continuity of welfare; controlling expenditure; and planning local and regional activities in a concerted manner. The agreement principle is one of the most important factors characterising the national departments, whose activities involve the municipalities, voluntary associations and NGOs. The latter are authorised by the public sector and almost totally manage the residential and semi-residential structures throughout the country, receiving a daily fee from the ASL for each person in treatment.

During 2006, 82.7% of patients received treatment in the SerTs, 7% in therapeutic communities and 10.3% in prison and remand centres. However, the drop in resources and the increase in demand are causing problems for the integrated intervention model, both in the public and private domain. Therapeutic communities fell in number from 1372 in 1996 (with about 24 000 users per year) to 730 in 2006 (with about 11 000 users per year), while in the SerTs the operator/user ratio has fallen to 1:24, with peaks of 1:30 in the big cities (the standard ratio set by Ministerial Decree No. 444/90 is 1:13.6). The reduction in staff, caused by lack of recruitment and high turnover, concerned mainly psychosocial posts (social assistants, educators, sociologists and psychologists) resulting in the fact that doctors and nurses now represent 50% of the 7 200 professionals employed in the 544 national SerTs.

While not underestimating the medical aspect of treatment, it is surely alarming that more than half of the substitution treatments carried out in Italy in 2006 were not linked to psychosocial treatment. Some research seems to confirm that the Italian SerTs, with their 180 000 annual patients, are today very close to saturation point. This has implications as it makes it difficult, on the one hand, to diversify treatment as required by the changeable nature of drug-related problems, and, on the other, to maintain the quality standards that have made the Italian model one of the most accessible and efficient in Europe as regards addiction treatment.

4.3 The normative framework

This situation is made more complex by the fact that drug consumption is a criminal offence and that coherence in the system is not at all apparent. This impacts on the normative framework and also ignores failures in the addiction services system. The present law (49/2006) requires the SerTs to take on many more duties in terms of inspection of addiction conditions, collaboration with prefectures and socio-health management of prison inmates, 35% of whom (60% in the big cities) are addicts. The SerT, the only service provider authorised to sanction a person's addiction, are thus called on by prefectures, by courts and soon by specific professional sectors too, to make a medical-legal evaluation which would have to be supported by appropriate training and professional resources.

5. Services

The departmental structure of addiction services is meant to guarantee the co-ordination and continuity of different specific treatment interventions, both vertically (prevention, risk reduction, treatment, social reintegration) and horizontally. It is based on patient characteristics (heroin, cocaine or alcohol addiction, dual diagnosis, mothers with children, etc.) and on the type of treatment (psychiatric, socio-educational, psychological, etc.) and service (outpatient, inpatient, residential, semi-residential, etc.). Each department organises these interventions in accordance with its reference area and available resources. The SerTs represent the common operational basis of all the national addiction departments, because of their responsibility for reception, diagnosis and treatment of people with psychoactive drug abuse problems.

5.1 Detoxification

As regards the medical dimension, diagnosis is the first step towards a detoxification programme, which can be short term (<30 days) or medium term (>30 days <six months), according to clinical evaluations made by the referring SerT. In 2006, detoxification treatments represented 50% of all medication assisted treatments, and this applied to 62% of the total number of patients (more than 100 000 persons: third in the world after the US and UK).

Most of these treatments (93%) consisted of administering opioid agonists: 68% of the patients were treated with methadone, 20% with buprenorphine, 4% with both methadone and buprenorphine (alternately) and 7% with some other medication, including non-opioid antagonists (naltrexone, disulfiram, GHB (gamma-hydroxybutyric acid), clonidine and others). The detoxification plan, usually prescribed for new clients, is managed by the SerT and can be carried out together with therapeutic communities when there is a

high risk of relapse. Most detoxification treatments are planned for heroin addiction, but other detoxification interventions are considered for patients dependent on alcohol, cocaine or other substances for which non-specific substitution drugs have to be used. For these clients, the main treatment involves psychological therapies (frequently group therapy), if necessary in association with pharmacological therapy, for example antidepressants, in order to reduce craving and increase compliance.

5.2 Evaluation/planning

In recent years, Italian pathological addiction departments have paid special attention to the evaluation process, both in its clinical-diagnostic dimension and in the analysis of organisational efficiency. Some factors, such as the evolution of addiction problems, the need to compare the effectiveness of different therapeutic approaches and the necessity to monitor health expenditure, furthered the adoption of indicators and psychodiagnostic assessment instruments certified at international level. This has also been accompanied by the establishment of regional and national epidemiological observatories to check the dynamics of drug consumption models and the institutional responses to drug problems. The Reitox National Focal Point, through indicators established by the EMCDDA, annually collects data on:

- national drug policies;
- drug use in the population;
- profiles of patients in treatment;
- prevention activities;
- drug-related treatments;
- health/social correlates and appropriate responses;
- dynamics of the drug market;
- special issues (e.g. very young people, cocaine and crack, etc.)

This general overview is based on data collected by various agencies (National Research Council, the Integrated Multicentre Indicators System, health care services, law enforcement agencies, judicial system) and is used to assess whether the aims of the national drug policy have been fulfilled. However, there are other and more specific evaluation programmes carried out at local level or focused on specific issues:

- Each Italian region periodically analyses treatment demand and the functioning of its health care system in order to establish a three-year plan (piano sanitorio regionale – PSR) and to direct the health care services, including departments for pathological addictions, in promoting specific implementations.
- The ISS (Istituto Superiore de Sanità/National Institute of Health) supervises tobacco, alcohol and drug misuse at national level, organises

training courses for professionals and co-funds research projects, such as the VEdeTTE study or Cocaine Project.

– There are programmes to improve knowledge of the most widespread diagnostic instruments (e.g. the Addiction Severity Index (ASI), the Minnesota Multiphasic Personality Inventory (MMPI), the Structured Interview for Personality Disorders (SCID), etc.), in order to facilitate the follow-up steps required to develop comparable outcome evaluations.

5.3 Treatment

The integration of medical, psychological and socio-educational services offered by departments has been made more difficult by the emergence of new addiction problems. Many outpatient and residential services diversified their services, even creating structures intentionally dedicated to alcohol, cocaine or gambling addiction treatments, rather than to transversal categories such as minors, mothers with children or people with associated psychiatric pathologies. This, in turn, required the development of wider operative protocols together with other local and regional actors, such as social services, psychiatric services, the ordinary and juvenile courts, schools, hospitals and family doctors. Therefore, the specialisation of therapeutic programmes is on two levels: one internal, through the development of new competences and the acquisition of new skills by the professionals, one external, through the achievement of integrated protocols with other agencies.

5.3.1 Substitution treatment

In Italy substitution treatment is guaranteed in all SerTs, is subject to certification of drug addiction status, is defined depending on clinical evaluation and is accompanied by weekly urine tests. Methadone and buprenorphine are given over a considerable period of time in about the half of cases (53% and 54%). This has significantly decreased, however, compared to previous years when long-term treatment accounted for 65% of all pharmacological treatments. The dosage may vary according to several factors, but the evidence produced by many national and international studies, including the VEdeTTE study, indicates that the effectiveness of these treatments increases significantly with doses from 60 milligrams upwards, supported by psychosocial treatment. In fact, in 2006 only half of patients with substitution treatment also received psychosocial interventions, possibly a combination of counselling (42%), social services interventions (41%), psychotherapy (31%), and psychological support (27%). Patients who receive long-term substitution treatment are in most cases heroin addicts (only 5% cocaine), are on average older (35 years) than patients who undergo detoxification treatment and have been known to the SerT for many years (only 15% of new patients receive this type of treatment).

5.3.2 Drug-free treatment services

In 2006 approximately 64 000 people, 38% of SerT patients, received only psychosocial (drug-free) treatment. Compared to patients on substitution therapies this population is on average younger, more likely to be new patients and consumers of cannabis or cocaine, and a significant percentage (20%) were sent by law enforcement agencies. These consumers benefit mainly from psychological support and psychotherapy, but drug-free treatments also aim to maintain abstinence for patients who have completed the detoxification step and receive residential and social support (home and work search).

Patients receiving drug-free treatment thus are normally more likely to fall into the category of problematic users rather than drug addicts. They may be consumers of substances, such as cocaine and amphetamine-type stimulants, for which there is no specific substitution treatment, or detoxified users with a high risk of relapse. The treatments are similar because they are not pharmacologically based. They differ in terms of tools and goals, and may represent both a standalone treatment and the final stage of a more complex programme, which may also be residential to facilitate the maintenance of abstinence.

5.3.3 Dual diagnosis treatment

Psychiatric disturbances are increasingly associated with drug abuse and, although the departments for addiction have offered specific treatment for many years, the quality is still strongly influenced by the degree of cooperation with mental health services and psychiatric wards of the hospitals. Since it is not always easy to distinguish precisely what the prevalent symptoms are, whether the psychiatric disorder is caused by substance abuse, is pre-existing or generally associated, difficulties arise when assigning patients to the competent department. Of the Italian regions, 80% have specific inpatient and outpatient programmes for patients with dual diagnosis, but only in half of the cases is there a structured link between the addiction and the mental health services, in order to share therapeutic interventions.

The SIMI®Italia data collection system, based on a sample of 2 000 SerT patients, estimated that in 2006, there were 31% with positive psychiatric diagnosis, three fifths were men and 90% showed prevalent use of opiates. The strong presence of these patients led, in public and private services, to a progressive improvement of diagnostic skills, increasing the ability to detect psychiatric symptoms underlying drug addiction. At the same time, studies were carried out to find specific associations between psychological and pharmacological treatments, and facilities were opened for the residential acceptance of patients who require medical and nursing support around the clock.

5.3.4 In/outpatient

As mentioned above, SerT outpatient treatment and therapeutic community residential treatment constitute the main axis of the Italian health care system for pathological addiction. The SerTs represent the specialist units of the national health service (though in some regions similar units have been recently established by private groups), while the therapeutic communities are mostly run by non-profit organisations licensed by the national health system. Until a decade ago integration between outpatient and residential routes was almost exclusively geared to treating heroin addicts and provided standardised interventions, at least in the planning stages. Diagnosis and the therapeutic programme were arranged at the SerT, the stay in therapeutic communities lasted for at least 16-18 months with periodic monitoring, and there was then follow-up again at outpatient level. The changing consumption patterns precipitated a change in the process, which is still ongoing and consists of the reconstruction of these protocols, now enabling the residential structures to have greater therapeutic specialisation, professionalism and flexibility. This process modified the average time of stay, which is often shorter, and the content of residential programmes, where the educational component has been accompanied by psychological input, psychotherapy and psychiatric treatment.

The focus has shifted to specific phases of the programme (e.g. detoxification, substitution therapy or abstinence stabilisation, social reintegration, etc.). The link between public and private services, however, is not limited to co-management of the patients (about 8% of total) who undertake the residential routes. It also concerns implementation of local treatment in terms of semi-residential programmes, such as those activated at the day-care centres, home support for patients with physical illnesses, outpatient trials for specific categories of patients and secondary prevention and harm-reduction strategies.

5.3.5 Drug and/or alcohol

The dissemination of services specialised in the treatment of alcoholism is fairly recent but well established throughout the country. These services are mainly run by the departments for pathologic addictions and are operationally linked to the SerTs, although they often have their own units and staff. All services have developed expertise in alcohol treatment and set up programmes for alcohol addiction, usually are based on motivational groups and psychological support (often cognitive-behavioural), possibly integrated with residential programmes in specialised structures and/or with detoxification drug treatments (disulfiram, GHB, naltrexone, selective serotonin reuptake inhibitors (SSRIs)). In Italy there are also many Alcoholics Anonymous (AA) centres with their 12-step programmes, and clubs for alcoholics in treatment (CATs), inspired by the Hudolin "ecological"

approach. Their integration with public services, including those set up in the hospitals, varies according to the region.

Although the social perception of the level of the problem of alcoholism is still underestimated and considered less dangerous than the consumption of illicit drugs, both the scientific community and institutional players have developed a high awareness of acute and chronic damage associated with alcohol misuse. Nevertheless, the specific programmes for these patients are still insufficient to intercept and respond to a phenomenon that is historically widespread in several Italian regions and is increasingly affecting, often in combination with other consumption, new populations, such as very young people, teenagers, women and migrants. The National Institute of Statistics estimated that in 2007 almost a fifth of the population over 11 years old (almost 10 million people) had at least one risk behaviour (more than the recommended daily consumption of wine, beer or other alcoholic beverages, intake of alcohol outside mealtimes at least once a week, one or more episodes of binge-drinking). According to some estimates (Gruppo Epidemiologico della Società Italiana di Alcologia) in Italy there are 33 million drinkers, of whom 4 million are problematic and 1 600 000 are diagnosed as alcoholics; those in treatment in alcohol units amount to just 55 000-60 000.

5.3.6 Link to somatic and psychiatric treatment

The most important links between addiction services and other health care services are described in paragraph 5.3.3 and are related to co-operation with the mental health services. There may be other opportunities, however, for exchange processes in addition to those above that may improve knowledge of the latest developments and enable the forecasting of possible future scenarios. An example is collaboration with hospitals, especially with the internal medicine units and emergency units, where staff, in some cases, function as counsellors and provide guidance to consumers and, more rarely, provide detoxification. These experiences, although still limited to a few instances, may offer a significant contribution in terms of rapid response to the problems, acute and chronic, associated with drug misuse. They may also represent a privileged source of information about the spread of new substances and new patterns of consumption, which usually only come to the attention of specialised services when the phenomenon is at an advanced stage.

Along similar lines is the attempt which has been ongoing for several years, but is still unfinished, to strengthen collaboration with general practitioners, who could play a key role both in terms of first diagnosis and guidance, monitoring both medium- and long-term therapeutic pathways that are more easily determined by family doctors.

5.3.7 Rehabilitation services linked to treatment

The rehabilitation programmes geared towards the social reintegration of patients represent a crucial stage in the treatments offered by SerTs. In concept, they are one step in the main therapeutic programme, but in practice they are often an intrinsic component that runs parallel to educational and psychological interventions. The responsibility for these programmes is generally allocated to social workers who, together with educators, support the patient in particular with regard to housing and employment, namely the two fundamental rehabilitative axes, not just for addicts and ex-addicts. In practical terms this means helping the person in obtaining or in the management of a house and/or job, in the choice of training or retraining, and in obtaining subsidies or pensions.

Although there are specific laws to help more vulnerable people obtain better access to housing and work, these measures are often insufficient. They perform a very important function, paid for by social co-operatives that, thanks to specific programmes funded by national and European institutions, ensure more or less protected work to many people in difficulty.

Related to this and equally important is collaboration with the social services departments of the municipalities, although sometimes this reveals problems similar to those described for psychiatry. In this case, however, the difficulties are mainly related to institutional differentiation between the social and health dimension, which threatens to fragment people's needs, as the responses by these services have different mandates. The negative effects of this operational partition are particularly evident for those services (drop-in centres, mobile health units, hostels, low-threshold services) where the rehabilitation work is geared towards reducing the health risks in certain populations (homeless, migrants, etc.) whose health problems are closely linked to habits and life contexts.

5.3.8 Treatment of young people

The work aimed at young consumers consists mainly in prevention and information activities schools and in places of entertainment. Whenever possible, the aim is to limit the inclusion of adolescents and young adults in the circuit of institutional health care, favouring the creation of dedicated spaces, physical and now even virtual, to further the inclusion of individuals with relational problems and to avoid the emergence of problems related to drug consumption.

Even for the most critical situations, services are primarily directed at families, offering support in parenting skills and to the protection of the children. There are situations, linked to changes in juridical context and in patterns of drug consumption, which force services into more direct management of young people who abuse psychotropic substances occasionally, for example

when young people are taken into care by the prefectures or by other law enforcement agencies due to possession of drugs or drink driving. In these cases there is an initial consultation with the psychologists of the addiction units in the prefectures, that in 2006 reported about 40 000 cases, of which about 19 000 were young people aged between 14 and 25 years and 3 000 were minors. These services have a filter function and just a small proportion (15%) of cases is sent to the SerT. Other reports can be done by the juvenile court or by social services, but the decrease in the average age of first intake of drugs and the emergence of specific compulsive behaviours (such as those associated with eating disorders or alcohol abuse) is also causing an increase in spontaneous access to the health care system. Many departments, especially in urban centres, have activated outpatient programmes aimed specifically at young people. These programmes aim to increase and promote self-motivation to change, and are on the border between the preventive and therapeutic levels. The therapeutic communities often have structured modules dedicated to the inclusion of adolescents and young adults, regardless of the type of substance used, giving priority to age homogeneity and cultural similarities.

5.4 Gender issues

Talking about differences in gender implies attributing values both from biological data and from lifestyle to the different cultural models for women and men. Gender is a social construction which, stemming from biological data, differentiates between the evolutionary and cultural paths of men and women. Therefore, the approach to the problem of female addiction, regarding both sociological analysis and the profile of assistance programmes, cannot be gender blind. The mere fact of being a woman or a man reflects on health in a different manner because it influences the prospects of longevity: women live longer than men but are more vulnerable to certain pathologies, particularly psychiatric ones. What bio-psychosocial factors characterise female addiction as opposed to male addiction? From numerous studies it has emerged that women are vulnerable to certain risk factors that expose them to the problematic use of narcotic substances.

Risk factors include the following tendencies:

– women develop addiction more rapidly;
– women develop addiction to legal psychotropic substances (alcohol, nicotine, psycho-pharmaceuticals);
– women are more frequently victims of sexual and psychological abuse;
– women have a greater incidence of psychological illness and dual diagnosis;
– women are involved in the phenomenon of co-addiction to a greater degree.

Protective factors include the following tendencies:

– women try out narcotic substances less frequently than men;
– women have judicial problems less frequently;
– women have good longevity prospects.

For the female gender, even the work situation is often precarious and characterised by occupations requiring few qualifications. One of the most difficult problems to face and solve efficiently is that of ex-addicted women (often single parents) over 35 with dependent children. According to different studies, it has also emerged that the under-representation of women in addiction treatment may depend on poor accessibility to such services. More specifically, three types of barriers have been identified when considering treatment for women with problems of narcotic abuse, classified as follows:

1. *systemic* barriers: impediments to the development of services responding adequately to women's needs (for example, lack of knowledge of risk and protection factors linked to gender differences, lack of knowledge of real female and maternal needs);
2. *structural* barriers: the rejection by various services of addicted patients with dual diagnosis or those under pharmacological therapy; the extremely limited number of services providing assistance to narcotic-abuse mothers and their children; poor co-ordination and integration in the network between services that deal with different aspects of assistance for women with abuse problems, etc.
3. *socio-cultural and personal* barriers: fear of losing custody of their children, lack of support on the part of the original family and the partner; the need for authorisation from the partner in order to accede to treatment; strong social stigmatisation that inculcates in women a great sense of guilt and shame in being identified as narcotic-dependent; fear of abstinence from narcotic substances; lack of information on women's rights in the choice of treatment; long waiting lists; lack of confidence in treatment success, etc.

A great many services in Italy are organising themselves so that they can break down these barriers from the point of view of organisation, structure and service. For example they are developing initial streaming for males and females, gynaecological consultation within the services for addicts, diffusion of information for health promotion and the prevention of sexually transmitted diseases, as well as information regarding the rights to an informed and aware maternity.

5.4.1 Pregnant women/families with small children

In the last few decades the Italian jurisprudential orientation on the subject of the protection/care/tutelage of under-age children of women with

drug-abuse problems has moved in the direction of assuring the right of the child to grow up in the surroundings of his/her original family. The mother has the right to keep her child with her if she participates in a psychotherapeutic programme with the educational and social support of specialist treatment centres equipped for accepting the mother-child dyad. In Italy the first psychosocial/therapeutic communities to take responsibility for mothers with children and also for families with psychosocial problems dates back to the middle of the 1990s. Towards the end of this decade professional competences in this sector matured to the point of considering the narcotic-dependent female, with social and psychological assistance, as potentially capable of taking care of her own child, thereby recognising the right to keep her child with her and to exercise "parental authority" in his/her regard.

Initially the treatment projects developed in isolated circumstances without much attention to child protection, but in the space of a few years the importance of a network became apparent and so public and private services began to integrate their services in a concrete manner, working from a multidisciplinary viewpoint. In such a network approach it is possible to maximise the various professional competences of the operators and safeguard the specificity of distinct methodological approaches, thereby using the territorial resources present to maximum effect. Gradually later on, there emerged the need to formalise these network efforts, preparing documents that would facilitate interservice communications and protocols alongside the acceptance of women into treatment.

In 2001, the Ministry of Health instituted a research project in order to understand and evaluate the assistance programmes for addicted women and their children. This project resulted in "protocol for the acceptance of pregnant addicted women" for services and operators in the sector. The outcome of the analysis conducted in the research pointed to the good practices in place in Italy and selected four centres for their excellence in approach to addicts and maternity in some pilot regions of northern and central Italy: Piemonte, Veneto, Friuli Venezia Giulia and Emilia Romagna. Integrated treatment protocols provide for:

– early acceptance;
– joint activation of various treatment services that begin operation in pre and post-natal phases (SerT, family consultation services, hospital services, social services for minors and therapeutic communities);
– use of specialised mother-child therapeutic communities that offer a range of services: prevention and care facilities for minors, special treatment for drug-abuse-related problems, observation, evaluation of and support for parental functions, but above all a protective place that limits the use of narcotics and methadone during pregnancy to the minimum possible, thereby avoiding the consequent Neonatal Abstinence Syndrome in the child;

– activation and optimum use of a social network as a necessary implement for post-residential societal reinsertion and for prevention against relapse.

While the protocols for integrated assistance offer good prospects for the development of a network of operators surrounding each clinical case, this is also a delicate and complex situation requiring a great initial investment of economic and temporal resources. At present the relations between different services and between services and institutions remain poor from the point of view of common modes of expression and of cohesion in the objectives to be attained, resulting from the different cultural and methodological backgrounds of the services involved. In any case, the long and tiring network task is an investment that in the end repays the effort with a higher possibility of successful treatment.

5.5 Treatment within the criminal system

5.5.1 Notes on regulations

The criminal justice and prison system in Italy has special legislation which takes into account drug addiction and related criminal offences. The law which governs this problem is the Decree of the President of the Republic (DPR) No. 309/90, modified by the integration of Law No. 49/06. In conjunction with these general norms, also to be applied for the actual terms of imprisonment are the general regulations of the Italian penitentiary system (principally Law No. 354/75 and DPR No. 230/00).

The Italian penal system provides for severe sanctions in regard to trafficking in narcotic substances, a maximum penalty of 20 years imprisonment in serious cases (conspicuous quantities, recidivism, international drug trafficking), with the possibility of recognising aggravating or extenuating circumstances when deciding the punishment to be inflicted. However, an arrested person (where a state of addiction is recognised) may request to be admitted into programmes as an alternative to imprisonment: at home or within a private or public therapeutic community, in each case at the state's expense. Even after trial and definitive sentencing, an addicted felon may be released from prison in order to be admitted into alternative programmes in his/her own home (in less serious cases) or into a public or private therapeutic community. The competence regarding this type of criminal offence and the people committing them rests with the general courts, since the "drug courts" present in other countries do not exist in Italy. On the other hand, for some years various large Italian cities (Rome, Catania, Milan, Padova, etc.) have implemented experimental "immediately-after-arrest" programmes for admission into therapeutic communities and these programmes are now being validated according to the "Direttissimo" (most direct) scheme. The same laws apply to under-age individuals, but with greater possibilities for

alternative measures, as provided for by the penal code in regard to under-age felons (DPR No. 448/88).

5.5.2 The penitential structure in Italy

Under Law No. 241/06, the Italian Parliament conceded the opportunity to benefit from a free pardon[17] to those detained in Italian prisons (61 264 inmates), resulting in the reduction of approximately 30% of the total prison population (down to 38 847 inmates). By 31 January 2008, however, the number of inmates was again reaching critical levels: 49 605 inmates (47 354 men and 2 251 women), for a regulation capacity of 43 242 (maximum tolerance 63 515).

There are various penitentiary structures currently functioning in Italy: 205 for adults, with a total of 28 828 cells; 17 institutes for under-age offenders (IPMs) and 25 centres for under-age first offenders (CPAs). In addition there are 13 ministerial therapeutic communities for minors (CTMs), five judicial psychiatric hospitals, 16 non-hospital recovery areas for ailing inmates, 16 institutions for addicts, 14 local administrative co-ordinative structures (Provveditorati) and 46 territorial offices for extra-penitentiary services regarding alternative measures and security (UEPEs). These last, together with professional social workers, co-ordinate their action with that of the local entities to arrive at an integrated vision of the action to be taken in respect of an individual. The health service personnel working in prisons number about 5 000 of which a minimum number operate full-time (1-2%). Fifteen prison nursery schools operate in as many cities for children of female inmates (about 50).

5.5.3 Inmates

On 31 December 2007, there were 48 693 inmates (46 518 men and 2 175 women). Of these, 19 029 had been definitively sentenced; 9 642 were awaiting a first-degree appeal; 3 199 were awaiting a second-degree/Supreme Court appeal and 28 188 were awaiting trial (arrestees). Also included in the total of detainees are 1 476 people not classified exactly as inmates but as "persons interned" and therefore under security measures in judicial psychiatric hospitals.

Particular attention is now being paid to the continually increasing prison population composed of foreign citizens, both from outside the European Union (18 252: 17 212 men and 1 040 women) and from within the European

17. A free pardon was offered for all offences carrying a prison sentence of up to three years if the offence was committed before 2 May 2006. It also provided for a three-year sentence reduction for those with a longer sentence. Excluded from this amnesty were those committing particularly serious crimes and also those who, having benefited from this legislation, committed a crime punishable by more than two years' imprisonment in the five years following the application of the law.

Union (3 619: 3 299 men and 320 women). The non-European nations with the highest numbers of detainees are Morocco (3 804), Albania (2 235) and Tunisia (1 803). On the 30 June 2007 10 275 detainees were diagnosed as drug-addicted[18] (equal to 23.8% of the total with 9 960 men and 315 women). Of these 1 759 were under substitution treatment with methadone; in addition, another 897 (857 men and 40 women) had been diagnosed as alcohol-dependent (2%). There were also 693 individuals tested and found to be HIV-positive, equal to 6.7% of the total number of addicts. Of the foreigners present (15 658), 2 768 were drug-addicted (17.7%), and among these 89 were HIV-positive. The basic substance most frequently used was heroin, followed by cocaine, alcohol and cannabis. In 2006 the minors who passed through the services of the juvenile courts (*giustizia minorile*) numbered 857 and were defined as "users" of narcotics. The majority were of Italian nationality (71%), 12% were Moroccan and 9% were from eastern Europe. The substances most used were cannabis (75%), cocaine (11%) and opiates (5%). Male users predominated greatly over female users (4%). Those declaring daily use numbered 32%, while 21% reported occasional use. In 2006 there were 50 suicides, 640 attempted suicides, 4 276 acts of self-injury, 2 174 acts of aggression and 81 deaths attributed to "natural causes".

5.5.4 The HIV infection problem

Without doubt the most serious and worrying health problem in prisons since the 1990s has been the risk of HIV infection. The lack of available pharmacological treatment, together with limited knowledge of the problem on the part of health workers and prison police forces, has created situations of conflict and even harrowing events. Today health education is disseminated in prisons at all levels (with the close collaboration of the local health services) and this has reduced this phenomenon to a level that is now rarely the object of criticism. It must be noted, however, that most of the measures for the "reduction of damage" and for the prevention of HIV infection remain uninstitutionalised. At present, in Italian prisons there are no programmes for the exchange of syringes, for the supply of sterile needles, for any personal hygiene disinfectant or for condoms. Even arrangements for prescribing and administering substitution pharmaceuticals (methadone, buprenorphine, GHB) are not widespread and these are only slowly becoming more available. The "double health management" in Italian prisons (the classic "penitential medicine" run by the Ministry of Justice on the one hand and that of the national health services on the other) has not resulted in improved health services for detainees. On 30 June 2007, there

18. The diagnosis of alcohol addiction and drug addiction, the province of specialists, still encounters great difficulties in standardisation in relation to the non-specialist descriptions produced by the Ministry of Justice. As a matter of fact, the data produced by specialised national health structures reveals that governmental statistics underestimate the problem. While judicial records are perfectly reliable, they do not address the need for a clinical diagnosis.

were 831 HIV-infected detainees (775 men and 39 women – 1.8% of total detainees) in various stages of infection: asymptomatic (523), symptomatic (206) and affected with illnesses indicative of Aids (102). Out of all of these, 71.3% were addicts. One fact that needs rectification in order to lower these statistics is the low voluntary participation in HIV screening at prison institutions: 23% of the total of new admissions, revealing HIV-positive indications in 0.8% of cases. It is interesting to note that women submit to this screening more often than men. The Italian penal code permits release from prison confinement where serious health conditions exist and in particular if there is an additional HIV-related illness. In the first half of 2007, 88 ill people were released under house arrest.

5.5.5 Addiction treatment in prison and alternative measures

Legislative Decree No. 230 of 22 June 1999 definitively and completely transferred all responsibilities regarding addiction therapy and prevention to the national health service, which operates at three levels:

– Level I: prevention, intake, reception, evaluation and diagnosis;
– Level II: acceptance as patient and therapeutic project, monitoring, release;
– Level III: extenuated custody and experimental projects.

The chain of interceptive action seems very similar to that applied in all cases. The different context situation, however, necessitates a series of adjustments that take into account the presence of the penitentiary police and the "re-educational" initiatives of the penitentiary administration in the light of current laws.

Extenuated custody is a Ministry of Justice project instituted in 1988: it provides for the creation of "drug-free" areas or institutes where alcohol is banned, the use of psychotropic pharmaceuticals is reduced to a minimum and narcotics are obviously totally forbidden. Access to these structures is voluntary, upon request. A specifically created mixed committee composed of penitentiary and health authority representatives evaluates the request and either approves or denies it (approval may mean transfer from another prison in the area). Once the addicted patient has arrived at the institute, he/she signs a formal pledge to adhere to the prescribed treatment activities, the internal work prescribed, the project's rules, the ban on all drugs, and so forth. During his/her stay, the patient is prepared for entry into a therapeutic community as an alternative to imprisonment and is trained for an external work programme (if this is possible and compatible with the territory's financial resources). Extenuated custody is not to be considered as an alternative measure; it operates in 20 institutes nationally, with a total of 400 assisted patients. The special projects for addicted inmates are numerous, generally managed by the Ministry of Justice. Among these, of

prime importance are those related to the ascertainment of and treatment of psychological pathologies in the detainee population (dual diagnosis or psychiatric co-morbidity), and it is claimed that more than 50% of detainees suffer from these disorders. As of 30 June 2007, 1138 addicted inmates were in alternative care; in 2006 the cases assigned to alternative care numbered 8782.

5.5.6 Reorganisation of medical facilities in prisons

The law of 24 December 2007 (Article 2, paragraphs 283-284) declares that as of 1 January 2008, all health competences and functions for both adults and minors in prison are the responsibility of the national health service. This date therefore signalled the beginning of the sector's total restructuring, as happened in France in 1994. In the text of the law, it is possible to identify various areas of major interest to the field of addiction, described in the related Project for National Objectives. These are the following:

- general medicine and the evaluation of the state of health of new arrivals;
- specialist services;
- emergency services;
- contagious/infectious pathologies;
- prevention of, treatment of and rehabilitation from addiction;
- prevention, treatment and rehabilitation in the field of mental health;
- caring for the health of inmates and their children;
- caring for the health of immigrants.

6 Special issues

6.1 Cocaine addiction treatment

The increasing incidence of cocaine consumption in the Italian population, estimates rising from 1.1% in 2001 to 2.2% in 2005, created problems for the treatment services, in that they had to adapt their services to the users' drug of choice. The price reduction registered in recent years is one of the reasons why cocaine use became more widespread and was no longer an "elite drug", thus making it available to all social classes and to people of every age. This posed a problem related to multiple drug consumption, including to the patients still in treatment, who often linked cocaine use to that of heroin, methadone or psychiatric drugs.

These two groups, cocaine and heroin users, are distinguishable by many factors (ways of intake and contexts, the consumption stage and duration, the health, physical and psychological condition of the users, etc.), but this forced classification is now useful in identifying the two groups

in respect to addiction and public services. On the one hand it is essential to redirect the treatments addressed to people using cocaine, and these in most instances are not opiates users. As a result of this, public services and non-governmental organisations began experimentation into outpatient and residential treatment of cocaine addiction. For many SerTs this process involved reorganisation not only on the therapeutic side, but also from a structural point of view, through the preparation of designated areas, different from the spaces offered to other patients and the need to have more flexible timetables, allowing to people to keep their school or professional engagements.

This reorganisation happened within the context of the spontaneous and increasing demands on the judicial system, causing the SerTs to have to deal with a constant increase in the number of patients with primary cocaine consumption. In 2006 the incidence rate (28%) was double the prevalence estimate (14%). Non-governmental organisations also diversified their outpatient and residential activities providing suitable structures for treatment of cocaine users and planned therapeutic programmes. On the content level, the adoption of new intervention models drew its inspiration from the results of international research, especially in the US. Examples include the Drug Abuse Treatment Outcome Study (DATOS) and the Collaborative Cocaine Treatment Study (CCTS) promoted by the National Institute on Drug Abuse (NIDA), which proved that the most efficacious treatments were the ones based on the integration of many instruments, used according to the patient's characteristics. Among these treatments, the most efficacious are the psychotherapeutic ones, especially those based on a cognitive-behavioural approach linked to individual or group counselling interventions, but also self-help groups and residential programmes. In Italy this move has been promoted by the Ministry of Health in the form of a national Cocaine Project, which has come into operation and whose aims are to:

– point out the specialist services at local level;
– educate the socio-medical operators working in these services;
– distinguish the characteristics of the intercepted patients;
– measure the efficiency/effectiveness levels through the definition of standardised indicators;
– activate specialist operative units with public-private co-operation.

Remarkable progress has also been achieved on the pharmacological side, in research pointing to more efficacious treatments for cocaine addiction, and in particular relating to the management of the detoxification and relapse prevention phases. To the already advanced number of medications, including some antidepressants (e.g. fluoxetine, imipramine and desipramine), dopamine agonists (e.g. bromocriptine and amantadine) and opiates (buprenorphine), have been added other more novel treatments, such as

baclofen and the TA-CD vaccine, and Italy, along with other European countries, is involved in a protocol of experimentation that has now entered its third phase.

7 Strengths and weaknesses

The high territorial variability of addiction interventions makes it difficult to provide a general comment on the weaknesses and strengths of a system which shows strong local peculiarities. However, some general statements may be made as to the overall characteristics of the country and the Italian system.

The first aspect concerns the territorial centrality of the SerT in every region of the country. Their high visibility and accessibility still make them the favoured intermediaries not only for people directly suffering from pathological addictions, but also for health, social and judicial institutions to deal with problems associated to substance abuse. This involves an increasing and ever more diversified demand on services, requiring an adaptation of professional, structural and management practices, which are not easy to conciliate with daily operational practice. In the last few years, many outpatient and residential services have redefined their intervention procedures in order to provide an answer to the needs of specific new categories of patient (e.g. problematic users of cocaine and amphetamine-type stimulants, people suffering from psychiatric co-morbidity, mothers with under-age children at risk). These programmes require considerable investment, however, in terms of training, space and the drawing up of operational agreements with other territorial agencies. Thus, during the coming years the possibility of maintaining the territorial centrality acquired over the years by the public addiction services will be determined by the ability of these services to intercept an ever larger "hidden" population of users, both the new socially integrated users and the new marginal classes.

As well as the outreach dimension, it is necessary to think about the evolution of the diagnostic and therapeutic elements. The competencies acquired during the long experience of heroin addicts now have to be changed to service the new consumption trends, such as the use of cocaine in the light of the different forms of psychological and pharmacological treatments that are still in the course of development. In this regard, a considerable advantage is the easier access to scientific literature produced at national and international levels, and this factor brings one back to the need for investment to facilitate research and training. Because of the delay in the most recent scientific evidence affecting practice in the clinic it is essential that the gap between the theoretical and operative levels is reduced and there is an increase in staff training through qualifying courses.

In Italy there are many refresher courses, but there is no general training plan to organise them into a coherent model, in spite of the efforts of many teachers and researchers and a strong investment into the topic of pathological addictions by the Italian universities. Also, the evaluation systems, both clinical and relating to the effectiveness of the services, use different criteria and instruments. So it is necessary to increase the local research culture by strengthening individual competencies and supporting the appropriate model for data collection and dissemination of information. The ability to deal with increasingly different types of request also has to be developed side by side with the ability to understand these requests and to respond to them appropriately. It is also necessary to work on the improvement of diagnostic procedures and the preservation of a therapeutic network which, especially for patients who are heroin addicts, has till now been successful in guaranteeing continued and integrated cure.

Another strong point of the above-mentioned system is to be found in the close and consolidated collaboration between public and non-governmental organisations and services. This collaboration on the one hand guarantees the availability of a large range of therapeutic and rehabilitation instruments. It is accepted that with pathological addictions, in their "traditional" manifestations as well as in their more recent guise, linear cure programmes rarely work. On the contrary a succession of different instruments is needed and also many structural and professional resources.

So it is not sufficient simply to adapt the internal procedures that have been in operation in past years in most outpatient and residential services, but a redefinition is needed of methods of collaboration in a wider system perspective. Indeed it would be restrictive to think that this change could take place just through the drawing up of local protocols, though they are necessary, without them being connected to a programme of cultural, scientific and strategic co-operation. This would involve all the sector's professions and public opinion would need to be developed based on a less emotional but more realistic perception of a phenomenon that is no longer just associated with a few limited social groups.

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Ministero della Solidarietà Sociale – www.solidarietasociale.gov.it
Network Nazionale sulle Dipendenze – www.dronet.org
Nuovedroghe – www.nuovedroghe.it
Osservatorio Fumo Alcol e Droga – www.iss.it/ofad
Publiedit – www.publieditweb.it
Rete dei Centri di Documentazione sulle Dipendenze – www.retecedro.net
SOS Droga – www.droga.it
Web Cocaine Care – www.webcocare.it

8.2 Organisations

ALEA – Associazione per lo studio del gioco d'azzardo e dei comportamenti a rischio
ANLAIDS – Associazione Nazionale per la Lotta all'AIDS
ASCOPUBBLI – Associazione Comunità Terapeutiche Pubbliche per le Dipendenze Patologiche
CeIS – Centro Italiano di Solidarietà
CNCA – Coordinamento Nazionale Comunità d'Accoglienza
CoNOSCI – Coordinamento Nazionale Operatori per la Salute nelle Carceri Italiane
CSV – Centro Servizi per il Volontariato
ERIT – Federazione Europea delle Associazioni di Operatori delle Tossicodipendenze
FederSerd – Federazione Italiana Operatori dei Dipartimenti e dei Servizi delle Dipendenze
FICT – Federazione Italiana Comunità Terapeutiche
FIVOL – Fondazione Italiana per il Volontariato
FORUM Droghe
Gruppo SIMS – Studio Intervento Malattie Sociali
Itaca Italia
LILA – Lega Italiana Lotta all'AIDS
SIA – Società Italina di Alcologia
SIPDip – Società Italiana Psichiatria delle Dipendenze
SITD – Società Italiana Tossicodipendenze

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Portugal

1 Demography

Portugal has an approximate resident population (2006) of 10 599 095 and an area of 92 391 square kilometres. The population density is around 115.1 people per square kilometre. In the last quarter of 2007, the unemployment rate was 7.8%. There are 36 563 hospital beds in Portugal (Instituto Nacional de Estatística).

2 Epidemiology of drug use

The first national general population survey on the use of psychoactive substances was carried out in 2002. The questionnaire was used on a sample of 15 000 individuals, representative of the Portuguese population aged 15-64, at national and regional level.

Results indicate that 7.8% of individuals aged 15-64 had at least one experience (lifetime prevalence) of illicit substance use. The most mentioned substance in this context was undoubtedly cannabis (7.6%). For other drugs, lifetime prevalence was inferior to 1% (cocaine 0.9%, heroin 0.7%, ecstasy 0.7%, amphetamine 0.5% and LSD 0.4%).

Last year and last month prevalence were, as expected, inferior to lifetime prevalence. Respectively 3.4% and 2.5% of the respondents reported any type of substance use during the last year and during the last month. Again, cannabis use was predominant, but ecstasy, and not cocaine, followed as the second most used substance in these periods.

Variations were also verified at gender and age-group level. Use prevalence was generally higher among men for all age-groups, all substances and over all considered periods. Lifetime prevalence of the preferred substance shows, for women, identical values for ecstasy and cocaine, whereas among men the preferred drug is cocaine. On the other hand, while among women heroin was one of the least reported drugs, for men it was one of the most reported and was only surpassed by cannabis and cocaine. In fact, with the exception of LSD, lifetime prevalence for heroin and cocaine were those which presented the highest differences in use between women and men. On the other hand, amphetamine, cannabis and ecstasy lifetime prevalence presented more similar values among women and men.

Concerning more recent use prevalence (last month), the differences between the male and female gender groups were higher, except for cocaine where the opposite arises.

LSD and heroin use are not present in the last month prevalence among women and ecstasy and amphetamine use are also barely present. On the other hand, among men, use prevalence for heroin and cocaine in this period were identical and only surpassed by ecstasy. For this period, cocaine use presented the lowest differences in use prevalence between men and women.

Use prevalence was clearly higher in the lowest age-groups for the majority of substances and periods considered. Males aged 25-34 reported the highest figure for lifetime prevalence of cannabis but males aged 15-24 reported the highest last month prevalence for cannabis. The age-groups 15-24 and 25-34 reported the highest prevalence for ecstasy and LSD. For heroin, the highest prevalence was found in the age-groups 25-34 and 35-44. For cocaine and amphetamine the highest lifetime prevalence was reported for the 25-34 and 35-44 age-groups, but last month prevalence showed more cocaine use in younger individuals (15-24 and 25-34 age-groups) and more amphetamine use in the age groups 15-24 and 35-44.

In short, despite the use of cannabis being the highest reported in all age and gender groups, some differences were found in the use patterns of these sub-groups. Of particular importance is the preference of younger individuals for ecstasy and cocaine use and the higher prevalence of heroin use in males aged 25-34 and 35-44.

Finally, it should be noted that the comparison of these results with other available results from other European countries shows that illicit substance use among the general Portuguese population is the lowest in Europe, especially when lifetime prevalence of any drug is considered.

In 2007, the second general population survey was conducted. Final analyses and results are yet to be completed.

2.1 Drug-related deaths

The national definition of drug-related deaths is still based on data from the Special Mortality Register (SMR) due to limitations in the General Mortality Register (GMR) and for trend setting purposes.

Data from the GMR (Selection B of the EMCDDA Drug-Related Deaths (DRD) Protocol) continue to indicate a decrease which lasted from 1996 (114 cases) until 2005 (nine cases). The number of cases implies that breakdown data on them ceased to be available for privacy reasons.

Although acute drug-related deaths are not yet possible to identify amongst the cases reported by the SMR, it has been possible to identify the percentage of suspected acute drug-related deaths. In 2006, 216 cases with positive post mortem toxicological tests were reported by the SMR, a figure close to the one registered in 2005 (219) but an increase in comparison to previous years (156 in 2002, 152 in 2003 and 156 in 2004). Of the cases, 52% with

positive toxicological tests and information on the presumed aetiology of death were suspected to be acute drug-related deaths. This percentage, which decreased overall between 2000 and 2003 (72% in 2000, 73% in 2001, 58% in 2002 and 44% in 2003), increased in 2004 to 51% and again in 2005 to 58%, in comparison to previous years, and then decreased again in 2006.

Most of these episodes[19] occurred in individuals of the male gender (94%), mainly aged 30-39 (46%). Opiates are, again and in all age-groups, the main substance involved in drug-related deaths, except in the lowest age-group (<25 years), where cannabis was predominant. The age-group 35-39 reported the highest absolute values of opiates and cocaine cases.

Like in 2005, but not in previous years, cases where only one substance was detected were predominant (58%).

Once again opiates[20] were the main substance involved in drug-related deaths (62% of the cases compared with 67% in 2005, 69% in 2004, 64% in 2003, 69% in 2002, 81% in 2001, 88% in 2000 and 95% in 1999), followed by cocaine (35% compared with 48% in 2005, 49% in 2004, 37% in 2003 and 44% in 2002) and cannabis (27% compared with 12% in 2005, 10% in 2004, 22% in 2003 and 13% in 2002). In comparison to 2005, it is important to note the increase in the number of cannabis-related cases and the decrease in the number of cocaine and opiate cases.

In 84% of the cases, cocaine was found together with other substances (particularly opiates and/or alcohol). Methadone was detected in 8% of the cases, as in 2005. Amphetamine was detected in less than 3% of the cases (less than 1% in 2005 and 3% in 2004).

Alcohol was involved, in combination with other illicit drugs, in 28% of the cases (23% in 2005, 33% in 2004 and 26% in 2003) and in 16% of the cases medication was associated with other drugs (16% in 2005, 9% in 2004 and 3% in 2003).

2.2 Drug-related infectious diseases

On 31 March 2007, according to notification data from the Surveillance Centre of Transmissible Diseases (CVEDT) drawn from analytical tests, a decreasing trend concerning the percentage of drug users in the total number of notified HIV-positive cases since 1993 continues to be reported. From the 31 132 notifications ever received, 45% (46% in 2005 and 48% in 2004) were related to drug use. Considering the different stages covered by these notifications, 48% of the Aids cases, 40% of the Aids-related complex cases and 44% of the asymptomatic carrier cases were associated with drug use.

19. Percentages calculated on the cases for which information exists on the considered variables.
20. Includes heroin, morphine and codeine.

Taking only the 2006 notified cases, 37% of the Aids cases, 28% of the Aids-related complex cases and 19% of the asymptomatic carrier cases were associated with drug use.

This again reinforces the decreasing trend, verified since 1998, in the absolute numbers and percentage of drug users in the overall number of diagnosed Aids cases, despite the fact that, in 2005, HIV infection was included in the national list of diseases which requires mandatory notification.

In 2006 notified Aids cases related to drug use were mainly men (85% compared with 85% in 2005 and 88% in 2004), most of them (87%) were aged 20-39, (89% in 2005 and 90% in 2004), and 57% were aged 25-34 (58% in 2005 and 59% in 2004).

Drug users with Aids-related complex and asymptomatic carriers are mainly of the male gender and aged 20-39.

Concerning hepatitis B and C,[21] data available refer to the analytical tests made in drug users' subpopulations that required treatment in the public and accredited treatment structures.

In 2006, data on hepatitis B and C show that 3% of the tested active clients in outpatient treatment were positive for hepatitis B (AgHBS+) and 54% for hepatitis C (HCV+). These percentages were very similar to the ones verified in 2005, 2004 and 2003.

Of the tested clients, 3% in their first outpatient treatment episode were positive for hepatitis B (AgHBS+) and 42% for hepatitis C (HCV+). These percentages are similar to the ones verified in previous years, especially in the case of hepatitis C (39% in 2005, 44% in 2004, 45% in 2003, 64% in 2002, 45% in 2001 and 49% in 2000), but also for hepatitis B (3% in 2005, 2004 and 2003, 8% in 2002, 5% in 2001 and 10% in 2000).

In patients admitted to detoxification units the global[22] percentages were 9% for hepatitis B and 48% for hepatitis C, similar figures to the ones verified in previous years (5%, 9%, 7%, 10% and 7% in 2005, 2004, 2003, 2002

21. In 2006, results for hepatitis B were presented by 36% of all active clients in outpatient treatment, 29% of the clients in outpatient first treatment episodes, 83% of the clients of detoxification units (91% of the clients in public detoxification units and 75% of the clients in accredited ones) and 96% of the clients in therapeutic communities (100% of the clients in public therapeutic communities and 95% of the clients in accredited ones). Results for hepatitis C were presented by 39% of all active clients in outpatient treatment, 32% of the clients in outpatient first treatment episodes, 84% of the clients of detoxification units (93% of the clients in public detoxification units and 75% of the clients in accredited ones) and 97% of the clients in therapeutic communities (100% of the clients of public therapeutic communities and 97% of the clients in accredited ones).

22. Considering results per type of service but not differentiating between public and accredited units.

and 2001, respectively, for hepatitis B and 54%, 62%, 62%, 59% and 58% for hepatitis C).

In public and accredited therapeutic communities 6% of the clients were positive for hepatitis B and 43% for hepatitis C. The percentage of positive tested clients in these units in 2005, 2004, 2003, 2002, 2001 and 2000, respectively was 7%, 7%, 8%, 10%, 9% and 14% for hepatitis B, and 46%, 50%, 48%, 51% and 51% for hepatitis C. The percentage of positive tested clients in these units in 2005, 2004, 2003, 2002 and 2001, respectively was 7%, 7%, 8%, 10%, 9% and 14% for hepatitis B, and 46%, 50%, 48%, 51% and 51% for hepatitis C.

3 Short history of drug treatment

In 1976, the first drug-related governmental organisation was set up to co-ordinate the fight against illegal drugs. It was the Gabinete de Coordenação do Combate à Droga (GCCD – the Co-ordination Office for the Fight against Drugs). This office was under the Presidency of Ministers Council and it had the responsibility to co-ordinate two other institutions and collect data from them. These were the Centros de Estudo e Profilaxia da Droga (CEPD – Drug Addiction Prevention Research Centre), with responsibilities in the demand reduction field and from which evolved the first public services treatment, and the Centro de Investigação e Controle da Droga (CICD – Drug Control and Research Centre), with responsibilities in the supply reduction field. At that time, some hospitals, for example the Santa Maria Hospital in Lisbon, had specialised addiction treatment services, which had been operating since 1973. It is worth mentioning that the first methadone treatment experiences in Portugal were carried out in 1979.

When the CEPD was created in 1979, there were three regional delegations: Lisbon, Oporto and Coimbra. In 1987, the government approved an inter-ministerial project to fight drugs, called Projecto VIDA. This project aimed at prevention, treatment, rehabilitation and reintegration and to fight drug trafficking. The Taipas Centre opened in Lisbon, under the patronage of the Ministry of Health and it was the first unit exclusively aimed at treating drug addicts (abandoning a psychodynamic model for a bio-psychosocial one, using medical interventions). The Taipas Centre served as a model for the creation of other treatment centres for drug addicts (CATs),[23] with some professionals trained at the Taipas Centre, others with experience acquired in the Oporto and Coimbra CEPDs. This CAT network spread through every region, to district capitals and equally important cities, offering drug addicts prevention and treatment structures and support for their families.

23. The Centro de Atendimento a Toxicodependentes, Attendance Centre for Drug Addicts, is an outpatient clinic offering medical psychiatric and psychological support as well as professionals in social reintegration.

In 1990, these structures were integrated into a single service: the Serviço de Prevenção e Tratamento da Toxicodependência (SPTT – Drug Addiction Treatment and Prevention Service).[24]

The SPPT, which was merged with the Instituto Portugués da Droga e da Toxicodependência (IPDT – Portuguese Institute for Drugs and Drug Addiction) in 2002 to form the Institute on Drugs and Drug Addiction (IDT), eventually evolved into the current IDT IP[25] and started the first public drug addiction treatment centres network. In order to ensure sufficient public provision, the SPTT contracts "beds" from the private sector, charities and with-profit institutions.

The National Strategy against Drugs and Drug Addiction 1999-2004 defined drug addiction as a disease and, therefore, the whole concept of dealing with drug addicts is permeated with this humanistic paradigm. However, the law followed long after society had accepted this, notwithstanding political opposition from right-wing political sectors.

4 Organisation of treatment services

The IDT IP is an autonomous service under the Ministry of Health and deals with licit (alcohol) and illicit drugs. Its structure involves one central service and five regional delegations, including four detoxification units (in 2007) with 46 beds, three inpatient drug-free treatment centres (public therapeutic communities) with 56 beds, and two day centres with 40 places.

This public provision is complemented by contracted beds and places from the private sector: six detoxification units with 65 beds, 64 inpatient drug-free treatment centres (therapeutic communities) with 1 339 beds, four day centres with 175 places and three specialised alcohol units with outpatient clinics and detoxification inpatient clinics.

5 Services

5.1 Detoxification

Withdrawal treatment is mainly available in public and private[26] detoxification units. In 2006 there were 14 detoxification units (five public and nine private units) in mainland Portugal, a figure identical to 2005. In 2006, a decrease in the number of clients in detoxification units was registered (1 466 in public units and 1 205 in private units compared with 3 237 in 2005 and 3 059 in 2004).

24. See José Cunha Oliveira, "A history of Portuguese development of a drug-addiction attendance system", available at www.emcdda.europa.eu/attachements.cfm/att_2108_EN_Abstract_Jose%20Cunha%20Oliveira.doc.
25. Law Decree 221/2007, published on 29 May 2007.
26. Data from private units cover only the units accredited by the IDT.

As to the source of referral, in public units 99% of the clients came from other health services, mainly CATs (98%), whereas in private units 84% they also came from other health services, mainly CATs (81%), but 4% requested treatment due to family pressure and 2% were self-referred.

5.2 Treatment

5.2.1 Substitution treatment

In 2006, the number of clients in opioid substitution maintenance programmes represented 71% of the total active clients in the outpatient public treatment network, a 9% increase in comparison to 2005 and reinforcing the tendency of increase of previous years (66% in 2005, 64% in 2004, 57% in 2003, 50% in 2002, 40% in 2001, 36% in 2000 and 22% in 1999).

In 2006, 22 922 clients were registered in these programmes (21 054 in 2005): 4 833 cases were new admissions (4 206 in 2005) and 6 087 (5 222) left the programme during the year, 16% of them with medical release (17% in 2005).

A survey made each year on the 31 December allows differentiation in terms of opioid substances involved in this type of treatment.

On 31 December 2006, 16 835 clients were registered in the outpatient public treatment network substitution programmes, representing an increase of 8%, 9%, 27%, 30%, 55% and 90%, in comparison to the same date in 2005, 2004, 2003, 2002, 2001 and 2000, respectively. Of these:

– 73% (71% in 2005 and 72% in 2004) were registered in methadone programmes; and
– 27% (29% in 2005 and 28% in 2004) in buprenorphine programmes.

In comparison with the situation on the 31 December 2005, there was a fall in the percentage of clients registered in buprenorphine programmes. This was mainly due to the price of buprenorphine bought in pharmacies.

Nevertheless, buprenorphine continues to be considered a relevant option for opioid maintenance treatment, in particular for pregnant women, as it is associated with less risk of neonatal abstinence syndrome and with lesser severity and duration.

5.2.2 Drug-free treatment services

Inpatient long-term drug-free treatment is mainly available in public and private[27] therapeutic communities. In 2006, there were 73 therapeutic communities (three public and 70 private units) in mainland Portugal. In comparison to 2005 there was one more public therapeutic community.

27. Data from private units cover only the units accredited by the IDT.

Contrary to the decreasing figure that has been registered since 2002, in 2006 the number of registered clients in both public (110 clients, 68 in 2005) and private units (4 118 clients, 4 093 in 2005) increased in comparison to previous years.

Data from the public therapeutic communities indicate that 62% of their clients (41% in 2005 and 53% in 2004) in 2006 were admitted for the first time into a therapeutic community. Some 98% of the admissions (93% in 2005 and 96% in 2004) resulted from a therapeutic project.

2006 data for private therapeutic communities indicate that 48% (48% in 2005 and 50% in 2004) of the clients had been admitted for the first time in a therapeutic community in that year of which 42% (38% in 2005 and 32% in 2004) were admitted following a referral by a therapist.

5.2.3 Dual diagnosis treatment

This is carried out mainly by the IDT IP network – namely CAT outpatient clinics, detoxification units and therapeutic communities specialised in double treatment diagnosis.

5.2.4 Drug and/or alcohol and prescribed drugs

Nowadays it is possible for patients to go to the same clinics, though in the context of *problemas ligados ao àlcool* (PLA – alcohol-related problems) there are three special reference units, established at regional level, that deal with patients with alcohol-related problems and consist of outpatient care (ambulatory), inpatient (internment) and relapse prevention.

However, in some cases drug addicts suffering from alcohol-related problems may be treated within drug addiction centres, as is the case in smaller cities, where patients with PLA may attend CAT outpatient clinics.

5.2.5 Rehabilitation services linked to treatment

Responses to the social consequences of drug abuse in Portugal are mainly promoted by social reintegration programmes implemented by the IDT, the Instituto do Emprego e Formacao Profissional (IEFP – Institute of Employment and Vocational Training), the Instituto de Seguros Sociales (Social Security Institute) under the Ministério do Trabalho e da Solidariedade Social (Ministry of Labour and Social Solidarity) and by public and private treatment centres which consider reintegration to be part of the whole treatment process. In the criminal justice setting the Instituto de Reinserción Social (Institute for Social Reintegration) and the Direcção Geral dos Serviços Prisionais (Directorate General of Prisons) are the main actors in this area.

The main priorities established by the national plan for 2005-2012 in the field of rehabilitation are:

– to ensure the comprehensiveness and co-ordination of the rehabilitation resources in all aspects of the clients' lives and to facilitate the development of responsible and demanding life projects;
– to promote rehabilitation as a global process, involving all stakeholders in integrated responses, through an effective and participative management.

Governmental welfare centres at district level are responsible for the certification process of appropriate housing facilities for drug users after the initial treatment period. In 2006, 27 out of 28 halfway houses, for clients of treatment centres leaving with a programmed medical release or for individuals in prison after release, were active during the year involving a total of 277 individuals per month (315 in 2005) needing that type of service. The annual costs incurred in 2006 were €1 026 970 (€827 343 in 2005 and €420 438 in 2004) but this is only a partial estimate. In order to ensure quality of service, the institute regularly visits these projects on site.

Prevention programmes for young school drop-outs and young offenders may be funded by the IDT under Programme of Focused Intervention (PIF). In general they aim at developing preventive measures on the basis of the promotion of social integration, vocational counselling and pre-professional training. They may be implemented both in the school setting and outside of school.

The major actor in employment-related reinsertion activities in Portugal is the IEFP whose main objective in this area is to promote the social and professional (re)integration of recovered drug users or of drug users in treatment through their participation in professional training and job promotion initiatives. The referrals, made by the IEFP regional and local services, are usually combined with specific counselling and intervention in the clients' personal and social setting.

Particularly targeted at ex-drug users who have finished or are finishing a treatment programme is the programme Vida-Emprego (Resolution of the Council of Ministers No. 136/98 of 4 December 1998), implemented through five regional.

In 2006, this programme had a budget of €4 839 963 (€5 948 397 in 2005, €5 756 333 in 2004 and €5 994 835 in 2003). Data is also available since 1999 on request. In 2006, 1 403 initiatives were funded (1 593 in 2005, 1 428 in 2004 and 1 445 in 2003) and 804 companies, non-profit organisations and local and central administration services (715 in 2005 and 778 in 2004) were active partners in this programme. Of the initiatives in the framework of this programme, the northern region was responsible for

34%, the region of Lisbon and the Tagus Valley for 29%, the central region for 19%, the Alentejo region for 11% and the Algarve region for 7%, figures very similar to 2005 and 2004.

The IDT's regional delegation of the Algarve, traditionally the most proactive one at this level, also promoted specific reintegration programmes for recovering drug users:

– The SABER programme followed up 275 clients placed in 45 companies. Of these, 125 were, after the end of the programme, fully reintegrated in the work setting without any intervention from the programme.
– Through the Rede de Artesãos (Artisans' Network) programme, an EQUAL programme funded until 2005 which aims to promote pre-professional experiences to help integrate drug users, and professional training programmes, the regional delegation reached 181 individuals[28] (41 in 2005, 117 in 2004 and 115 in 2003). The programme involved a significant number of private businesses, non-profit organisations and local and central public administration services. This represented a 1.7% increase in the number of clients integrated in the Rede de Artesãos programme and a 34.7% increase in the number of employers involved in comparison to 2003. This programme was nominated, in 2006, as a best practice in the public service.

5.2.6 Treatment of young people

In order to respond to young people's needs, decentralised consultation points have been set up in branches of the Instituto Português da Juventude (Portuguese Youth Institute) and other structures aimed at young people.

5.3 Gender issues

5.3.1 Pregnant women/families with small children

As for other specific sub-groups of problematic drug users in treatment, one of the main concerns and priorities of CATs has been the admission and follow-up of pregnant women and those who have recently given birth with drug abuse problems. A specific working group was set up at the IDT, with experts from the IDT Research Unit and several CATs, to work on the collection of data on these women. Participation in this group was voluntary and it did not follow any inclusion or exclusion criteria. For that reason, the results cannot be applied to the national level and may not even be representative of each CAT's geographical area.

A form was used to collect the data in CATs concerning the period since the first pregnancy appointment until childbirth. The record consists of socio-demographic data, toxicological history and clinical data throughout

28. Some individuals may have attended the programme for more than one year.

pregnancy, as well as obstetric details and the situation of the child after childbirth. The sample in 2003 contained 317 individuals, 84 in 2004 and only 29 in 2005. A TeleForm® application was used for database storage and SPSS® for data analysis.

Results concerning the years 2003 to 2005 for pregnant women include the following:

- nearly half of the women were CAT clients at the time they became pregnant and were usually following a high-threshold substitution programme and psychotherapy;
- they asked for a specific pregnancy appointment at the CAT during the first trimester of pregnancy;
- they usually did not have other children;
- they were mainly aged between 24 and 30;
- they had completed either the 6th or the 9th grade at school;
- they were married or were living with a partner, usually someone with a drug use history;
- they were unemployed;
- they were already in treatment at the first appointment (consultation);
- they were mostly HIV-negative.

For the same period of time, those who had recently given birth reported:

- normal child delivery at between 38 and 40 weeks in hospitals;
- children weighing 2.5 kg or more;
- nearly half of the children had neonatal abstinence syndrome and were usually treated in neonatal units;
- child protection services were involved but the child stays with the mother (alone or with the involvement of other family members);
- a significant decrease in heroin use, sometimes total abstinence, coupled with an increase in tobacco use.[29]

It is also important to note that, from 2003 to 2005, fewer pregnant women tested positive for HIV, hepatitis B or hepatitis C.

The results of this project supported the interventions already available in CATs for pregnant drug users and their families in addition to providing some suggestions for future research and treatment. It also emphasised the importance of cohort studies and child development studies, co-operation and quality in the support network, early detection of risks and adequate referral and training for professionals.

29. At the time of their first pregnancy appointment 61.6% of 304 pregnant women were abstinent or only smoked tobacco, and during follow-up 63.0% of 208 were abstinent or only smoked tobacco, and this pattern was maintained during pregnancy for 77.3% of 168 women.

5.3.2 Other gender issues

In the military setting, in 2006, the armed forces collected 16 260 urine samples from contracted, volunteer and permanent staff (mandatory service ceased in 2005). The samples were mostly collected on a random basis but follow-up tests (after one positive test) and tests following drug-use suspicion reports are also included in these figures. The age-group 18-39 is over-represented in the sample due to the low mean age of servicemen and -women.

There were 72 056 toxicological tests performed on the collected samples for illicit drug use (cannabis, opiates, amphetamine and cocaine) and of these 1.3% tested positive, which represents a decrease in comparison to 2005 (1.5%), 2004 (2.3%) and 2003 (2.2%).

When considering the results per professional category, contracted personnel registered a higher percentage of positive tests (1.6%), immediately followed by the volunteer staff (1.5%) and the permanent staff ranked quite low at 0.06%. However, in 2006, in comparison to 2005, a decrease in the percentage of positive results was registered in all categories of staff. The main illicit substance found was cannabis (93% of all positive tests, 86% in 2005) and positive tests for opiates, cocaine and amphetamine (alone or together with other substances) were residual.

5.4 Treatment within the criminal system

In the specific area of abstinence-oriented treatment in the prison setting, in 2006, a new drug-free unit became available, increasing to seven the number of drug-free units in seven prisons with a total capacity for 200 (179 last year) individuals. The therapeutic community with a capacity for 45 individuals and one halfway house with a capacity for 12 beds remain available.

In 2006, there were 263 inmates in the drug-free units, which represented a variation of +8%, +13%, -25%, +17%, -2% and -3% in comparison to, respectively, 2005, 2004, 2003, 2002, 2001 and 2000. There were 74 inmates following a programme in the therapeutic community, which represented a variation of +51%, -27%, -23%, 0%, +11% and -42% in comparison to, respectively, 2005, 2004, 2003, 2002, 2001 and 2000. There were 19 inmates registered in the halfway house representing an increase in comparison to 2005 (14 clients).

Concerning the place of administration for the clients registered in IDT IP methadone programmes, on the 31 December 2006, 4% (as in 2005 and 2004) were in the prison setting.

In the particular case of the prison setting, a 5% increase was verified in the number of clients using methadone prescribed by CATs (533 clients on 31 December 2006 in comparison to 463 on 31 December 2005), but

administered in the prison setting. The number of clients using methadone prescribed by the health services of prisons registered the lowest figure in the last seven years with a total of 258 individuals on 31 December 2006, a decrease of 5%, 14%, 21%, 3%, 29% and 21% in comparison to 2004, 2003, 2002, 2001 and 2000, respectively.

6 Special issues

Prevention of drug-related infectious diseases amongst problematic drug users is mainly ensured through the national syringe exchange programme "Dizer não a seringa em segunda mão" ("Say no to a second hand syringe"), established by the Comissão Nacional de Luta Contra a Sida (CNLCS – National Commission for the Fight against AIDS) in collaboration with the Associação Nacional das Farmácias (ANF – National Association of Pharmacies) and the IDT IP. Since it was set up, in October 1993, it has used the national network of pharmacies and has enlarged its partner network through protocols with mobile units, NGOs and other organisations in order to reach a wider population. This programme was externally evaluated in 2002 (as reported in previous national reports) and it was concluded that it had avoided 7 000 new HIV infections per each 10 000 injecting drug users during the eight years of existence of this programme.

Between October 1993 and December 2006, 38 282 762 syringes were exchanged through this programme. In 2006, 2 591 150 syringes were exchanged, which represented an 8.9% decrease in comparison to 2005. These syringes are included in a kit with two syringes, two disinfecting towels with 70º alcohol, one condom, one ampoule of bi-distilled water, one filter and an information leaflet.

In 2006, 1 341 pharmacies (1 327 in 2005) were active in this programme (48% of the existing pharmacies in the country – 48% in 2005). Those pharmacies exchanged 1 368 322 syringes (1 412 732 in 2005), representing more than 52.8% of the total of syringes exchanged in 2006 in the framework of this programme (49% in 2005).

The mobile units of Cova da Moura (set up in July 2002) and Odivelas (set up in October 2003), exchanged 18 112 syringes in 2006, representing 0.69% of the total of syringes exchanged (22 406, 0.78% in 2005).

The remaining syringes – 1 204 716 (1 409 973 in 2005) – were exchanged by the other 35 partners of the programme, representing 46.5% of the total number of exchanged syringes in 2006 (49.5% in 2005) in the context of the programme.

The districts of Lisbon, Porto and Setúbal continued to be the ones that registered the highest number of syringes collected since the beginning of

the programme, representing nearly 46%, 20% and 10%, respectively, 76% of the total number of exchanged syringes.

Andrade et al. (2007), followed up and assessed, during one year (2004 to 2005), a drug user population of 331, contacted by outreach workers (15 projects nationwide from the existing 24). Data was collected during the first contact, in 2004, through a standard form (client profile) and again in 2005 using a different standard form (client evaluation). The client profile form collects socio-demographic, family, drug-use history, treatment, risk behaviour, medical, criminal and follow-up and referral data. The client evaluation form collects the same data to allow for an assessment of progress. The forms are filled in by an outreach worker, when a close relationship with the user is established, in the user's setting. The user is informed about the objective of the data collecting and the confidentiality of his/her data. The collected data were stored and analysed with using SPSS® 14.0 for Windows.

Interventions by the outreach workers involved in these projects respected quite closely the plan for each semester and included mainly social support (in 85.2% of the cases), psychological support (in 60.1% of the cases) and food provision (in 50.5% of the cases). Other, less requested, interventions were hygiene care, nursing care, medical care, medication provision, low-threshold substitution and legal support.

Referrals were made mainly to outpatient treatment centres (CATs) and to the social services, though a significant percentage was referred to the local health centres or to a hospital.

Due to the fact that since July 2001 private consumption of illicit drugs is not a crime but is subject to an administrative sanction, consumers in public areas are taken by the police to the dissuasion commissions, composed of psychologists, law specialists and other related professionals who assess their drug addiction and refer them to treatment as necessary.

This public policy allows for early consumers to be noted and made subject to prevention interventions and/or to be treated.

7 Strengths and weaknesses

Weaknesses:

- lack of human resources;
- lack of funding to carry on more reintegration projects;
- distance from out patient's home to CATs;
- price of certain therapies.

Strengths:

- quality of interventions;

– treatments offered are varied;
– focus on the citizen.

8. References

8.1 Websites

www.idt.pt

8.2 Organisations

Institute for Drugs and Drug Addiction

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8.3 Literature

May be found on the IDT IP website other than that cited.

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