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.