



ERIT

FEDERATION OF EUROPEAN PROFESSIONALS  
WORKING IN THE FIELD OF DRUG ABUSE

# EXPLORATORY STUDY ON OPIATE SUBSTITUTION IN EUROPE



With the support of the European Commission





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Project Manager:  
**Dr. Luís Patrício**  
Editing:  
**Domingos Duran**



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## INDEX:

I.	<i>General Presentation</i> .....	7
II.	<i>Presentation of the Study</i> <i>The reason for an Exploratory Study</i> .....	9
III.	<i>Methodology:</i>	
	a) <i>1st Methodological Question:</i> <i>The representativeness</i> .....	13
	b) <i>2nd Methodological Question:</i> <i>The instruments for the analysis</i> .....	17
	c) <i>3rd Methodological Question:</i> <i>The Circulation of the Information:</i> .....	18
IV.	<i>Evaluation of Results:</i>	
	a) <i>Evaluation of the representativeness</i> .....	21
	b) <i>Evaluation of the adaptation of the</i> <i>instruments for the analysis</i> .....	24
	c) <i>Evaluation of the debates methodology</i> .....	25
	d) <i>Evaluation of the results</i> .....	26
V.	<i>Conclusions</i> .....	29
VI.	<i>Recommendations</i> .....	33
<i>Annexes:</i>		
A.	<i>List of Participant European Experts</i> <i>/ Characterization of the Group of Experts</i> .....	35
B.	<i>Questionnaires</i> .....	39



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## ***I. GENERAL PRESENTATION***

Since its inception in 1992, and in accordance with the statutes by which it is ruled, the ERIT Federation has been conducting efforts with the objective of promoting the exchange of knowledge and the increased technical competency of the European professionals that work in the field of drug addiction. Representing 15 national associations from 9 European countries, ERIT is regarded as a real forum for debate and the exchange of experiences by people involved in the field of drug addiction, in this way contributing to the depth of the investigation and the understanding of this phenomenon.

The manner in which ERIT has been conducting its activities in this field is shrouded with some complexity: there are various ways in which the Federation carries out its statutory mandate. Among them, the more visible ones are the European Conferences (Liège 1993, Paris 1996, Bologna 1998, Porto 2000 and possibly Berlin 2002), which gather in an open forum for debate thousands of professionals and social organizations involved in the fight against drug addiction, as well as ERIT's Work Groups. These groups, lead by members of ERIT's Council of Administration, have as their objective the investigation of topics that are current and relevant to the discussion about the drug phenomenon in Europe. They are composed of national experts (not necessarily from ERIT's member-associations) that, in their activities, favour the exchange of information and the analysis of the situation in various countries, from which an evaluation of common problems is conducted and, eventually, a concerted response is prepared.

Since these Work Groups have been functioning for years and,



as such, have done a considerable amount of work yielding significant results, ERIT's Council of Administration decided to promote the publication of the aforementioned reports, as a way to publicize the nature of the work done and the guidelines that have been highlighted thus far.

More than definitive statements regarding the nature of drug addiction and the phenomena associated with it, the conclusions and recommendations put forth in these publications reflect the current status of the situation in regards to the expression and evolution of the drug phenomenon in Europe, as well as what has been done in view of a concerted response.



## ***II. PRESENTATION OF THE STUDY.***

### ***The reason for an Exploratory Study***

The methodologies of opiate substitution play a progressively more important role in European services made available to people who misuse drugs. That importance is not only revealed by the growing amount of drug misuse that benefits from this type of intervention, but also by the increased scientific and technical interest about these methodologies, which can be assessed by the availability of a larger variety of options for opiate substitution: from an initial panorama in which methadone appeared as almost the only therapeutic possibility, the European reality is now characterized by a more diversified therapeutic arsenal, allowing the use of alternate substances (LAAM, High Dose Buprenorphine , Morphine, Heroin), inserted in different intervention practices (treatment, harm and risk reduction).

A deep investigation of the reasons for such an evolution doesn't fit into the framework of this study. All the same, the impositions of a new reality in terms of public health related to the spread of HIV (and other associated infectious diseases, such as Tuberculosis) among intravenous drug users, as well as other infectious diseases related to the use of drugs (viral hepatitis), surely had a very important part in this change of practices. Pressed by these factors, the European professionals (in consonance with political decisions of the national, regional or local authorities of their countries of origin) tried to develop practices of opiate substitution that would allow them to deal with and improve the troubling sanitary situation that was about to become a reality. By doing so, they



necessarily took into account their own reality, and the need for providing an answer not only to the basic common characteristics of the problem, but also to the local, regional and national specificities, that it was essential to face.

To this extent, and once again, the changing and unpredictable phenomenon of drugs imposed its law. The urgency of new immediate answers led to new real practices, which developed in the sense of the fast adaptation to the new sanitary dangers. Without time to react in a global and articulate way, professionals have acted in favour of giving the people who misuse drugs the means judged more effective to combat the new threats - the way these new means are articulated with the structure of already existing services, and the organization of a global and synergetic answer at a regional or national level is, therefore, an unaccomplished task.

As a result of this situation, valid for all of the Union countries, modalities of opiate substitution have been developed; these modalities undoubtedly share common elements, but, as a result of the context and of the aims of the interventions for which they are used, they differ a lot from country to country, and frequently, even from an area to another. Throughout the years, the fact that services, professionals and the interventions are exposed to a changing and demanding reality in what social-sanitary conditions are concerned produced different evolutions in the planning of programs, in their characteristics and criteria, in the achieved results, and in the assessment in the context of the proposed initial aims. As a consequence, interventions that seemed similar at the beginning (same substitution substance, same aims, same inclusion / exclusion criteria) have developed in very different ways, creating new practices, goals and the



valorisation of results, as a product of their inclusion in different national, regional and sanitary contexts.

Thus, the present situation in what concerns European practices of opiate substitution is varied and complex, sometimes even appearing to be contradictory. As a European federation of drug workers, ERIT has been attentive to these disparities; starting with this general analysis, and being in a privileged position among the European professionals, encouraged by its statutory priorities, and with the support of the DGSPC of EC, the possibility to carry out an exploratory study on practices of opiate substitution in the European context seemed logical. For this purpose, a forum for debate among experts coming from several European countries was created. These experts should identify technical and professional characteristics that would allow the final conclusions to be representative of the different European realities.

After the constitution of the Working Group, it would be interesting to find a methodology to better allow the definition of the key-subjects for the comparison of experiences, and the debate about the interventions. For this purpose, a methodology of knowledge exchange developed by ANIT Portugal was used (and with good practical results since several years ago). The conclusions that came from the discussions, the consensus on the practices of opiate substitution will have to be faced as the result of an exploratory investigation - thus, and to completely accomplish the objectives defined by this situation, in the final chapter of this project we will find not only the conclusions and recommendations that the state of the present art allows us to emphasize (areas where there is a consensus among the experts), but mainly the determination of the fields and study areas that urgently need to be developed and deepened.



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### **III. METHODOLOGIES**

All the means, measures and results discussed in this Report should be looked upon in accordance with the main characteristic that was in the origin of the project - an Exploratory Study.

In this sense, the obtained results, whether you see them at a methodological level, or at the level of conclusions and recommendations, should always obey and be included to that extent.

This study tries to define clearly which of the investigation and evaluation areas should be deepened, in order to come to a deep analysis of what today, the model or the models of opiate substitution in Europe are; it doesn't try to find definitive conclusions about an exhausting evaluation of the practices of opiate substitution in Europe; this is achieved through the mobilized means and the implemented strategies.

#### **a) 1st Methodological Question - Representation**

The first methodological subject to consider for the accomplishment of this study had to do with its coverage: an exploratory study, outlined with the only aim of rising heuristic questions that should lead to a subsequent investigation.

**Map 1. Definition of the epistemological and methodological characteristics of the Exploratory Study, in comparison to the classic Evaluation Study**

	Evaluative Study	Exploratory Study
Epistemological Goals	It tests the model (theoretical, evaluation) generator of the hypothesis, in reality (model - > empiricism)	Analysis of the reality, seeking changes of the model (heuristic movement: empiric goal-analysis - > model)
Validity	It seeks the direct analysis of the reality	It seeks the goal: analysis about the reality
Sample	<u>Statistical criteria:</u> Theory of Sampling Priorities: - Direct access to the universe of the evaluation - Dimension of sample - Aleatory condition vs. Stratification	<u>Quality of analysis:</u> Priorities: - The quality of the observers of the reality - Nodal location in the informative networks on the phenomenon
Methodologies	Direct evaluation of the phenomenon	Evaluation of the information: analysis of the phenomenon (observers' productions)
Results	Based on quantitative criteria (evaluations of effectiveness: averages, frequencies, distribution of results)	Contents analyses
Conclusions	They allow direct intervention in the reality	Conclusions with no direct impact on reality, they must be integrated in a higher elaboration level (theory, system) - > new hypothesis - > test



Unlike an exhausting evaluation study of the opiate substitution practices, where all its validity would depend on getting a representative and significant sample of the substitution practices taking place in Europe, an exploratory study requests above all that the contributions of information can, in the most economical way, supply a level of analysis of the reality that is reliable, and that generates good hypothesis, the ones whose investigation can take the analysis models to a new type of conclusions.

Thus, the first methodological concern was the one to find the main points of the networks, that is to say, the national experts who, as a result of their present and past practice, could be placed in the confluence of the local circuits of information on substitution therapies.

In the introductory chapter, it was presented how it was possible for us to achieve that goal in an economical way:

- The criterion that presided over the selection of the participant experts in this study was based not only on their technical competence, but also on their previous experience in terms of administration of programs (at a regional or national level), supervision and evaluation of substitution practices.
- On the other hand, we tried to congregate participants from many European countries, inclusively from countries out of the European Union

As for the achievement of the first aim, we tried to organize it in the following manner:



- In the first place, to look for an expert in each country who, as a result of their experience in managing, supervising or evaluating substitution programs, could serve as a nodal point of the information regarding his country.
- When that was not possible, we looked for experts to serve as nodal points relating to the information related to an area of his country.
- To look for experts in reference services in each country / area

Whenever possible, and as a means of improving the representation of the group in what the reality of the European substitution practices is concerned, we tried to combine several of these aspects, thus generating the possibility of having different visions on the same national realities in confrontation.

In what the second operational aim is concerned, the structure of ERIT itself served as a basis for its achievement. Through the member-associations of the Federation, and through their resources, it was possible to establish the following procedures:

1st step: Identification of the national experts who were included in the criteria referred in the first aim.

2nd step: Use of the member associations contacts in the eastern countries, for eventual participation of experts in this study



3rd step: After the elaboration of the list, according to the indications of the associations of ERIT, contacts were made with the experts, in many cases facilitated by those same associations.

**(Note:** Achievement of aims 1 and 2 - List of Experts and respective professional present qualifications, and Characterization of the Experts according to their clinical experience with opiate substitutes, in Annex I)

**b) 2nd Methodological Question -The Instruments of Analysis:**

After having gathered the experts according to the criteria already presented, it was important to create working methods to allow us to define the relevant contents that would point out the capacities and the meta-analysis work accomplished by each one, analysing the realities known to them. To accomplish this, we used a methodology developed by ANIT Portugal, in the national residential seminars among experts. This methodology serves a double purpose:

- To allow for the creation of a work instrument that facilitates the analysis of discussions' content, guiding this analysis in the sense of the relevance of the studied topics, about the reality. This methodology consists in asking the summoned experts to elaborate the questions they believe to be the most relevant for the Study (open questions – free answers, and closed questions - answers yes / no, or numerical), so that they are included in the questionnaire that later will be answered by all the participants. So the Questionnaires (that were the basis



of the project) were built out of contributions from each one, (Annexes I and II. Open and Closed Questions).

- To make the discussion easier, due to the content of the answers, where, after the confrontation of the experts' opinions in view of the answer tendencies shown by the group, the results of the Study are as follows:

- In the first place, the evaluation of the agreement or disagreement level among the experts is immediately accessible

***High Level of divergence:*** Recommendations with great importance for the practice, but of low heuristic saturation

***High Level of divergence:*** Recommendations for investigation, with a high heuristic saturation, and causing no impact on the practice of the services

### **c) 3rd Methodological Question - the Circulation of the Information**

The dynamics of this study implicated several specific moments, in what the circulation of the information among the European experts is concerned. After the identification phases and the contact with the European experts, the chosen methodology for this study determined that the analysis instrument was built, the way we presented it previously. For this purpose, each European expert sent three open and three closed questions, from which, and after adaptations and removal of the redundancies, the Opened and Closed



Questionnaires were built.

The phases that followed had the following sequence, until the evaluation elements that constituted the operational aims of the study were achieved:

- 1) To make the circulation of the information and the analysis of results easier, and to make a deeper and more meticulous discussion of the answer tendencies registered in the questionnaires, the experts were divided in two groups, according to their origin. In the Northern Europe Group, there were experts from Germany, Austria, Belgium, Poland, Slovenia and United Kingdom; in the Southern Europe Group there were experts from France, Spain, Italy, Portugal, the French-speaking part of Switzerland and Greece. For each Group there was a Reporter (Dr. John Merrill, and Dr Paula Brum, respectively); they had the mission of making the first collection of qualitative results, and of later, integrating those results with the quantitative data that came out of the content analysis of the answers given in the questionnaires.
- 2) The questionnaires circulated among the experts of both Groups (e-mail, fax, traditional mail), in the diffusion phase, as in the phase of collecting and spreading the results and their analysis; there were still Group meetings where the tendencies of answers were discussed. Each Reporter has registered and analysed the data of the discussion in the results verified among the experts.
- 3) In ERIT's IV European Conference, that took place in Porto in February 2000, the two Groups met, and each



Reporter presented the first results of his/her Group publicly. On that occasion, it was possible to attend a debate of the whole of results of the two Groups, not only on the part of the experts, but also counting with a special contribution from the public. This procedure allowed the enrichment of the conclusions that came out of the discussions of each Group, standardizing them and integrating them in a more general European reality.

- 4) With the numeric results related to the answers of each Group, with the results of the discussions on each Group's results, and even re-standardizing these elements registered in the specific seminar that took place in the IV Conference could this report be made, according to the epistemological and methodological goals initially established.



## **IV. EVALUATION OF RESULTS**

### **a) Evaluation of the representation:**

In the chapter on the methodology, the aim of representation was achieved according to a pre-established order of procedures, which sought to guarantee that the participant experts in the Group would be real nodal points of the national or regional information network on the clinical experiences with substitution therapies:

**1st Criterion** - National Expert with managing, supervising or evaluating substitution programs experience, serving as a nodal point of the information regarding his country.

**2nd Criterion** – Experts who behave as a nodal point in relation to the information regarding an area of their country.

**3rd Criterion** - Experts of reference services in each country / area

By analysing the contents of Annex 1, we verified that the study congregated experts of 12 European countries, **(9 countries of the Union, together with Switzerland, Poland and Slovenia)**. In what the carrying out of representation is concerned, and taking into consideration the type of information supplied by the experts during the discussions (types of information used for the study: regional, local or national), as well as a contrast between it and the previous experiences on administration, supervision and evaluation of programs of opiate substitution, the evaluation (per country) of the contributions of the experts involved in this study can be schematised in the following Map:

**Map 2. - Contributions of the Experts according to the criteria to carry out Representation:**

COUNTRY	ACCOMPLISHED CRITERIA			TOTAL
	1st	2nd	3rd	
FRANCE	+	+	-	1+2
GERMANY	+	-	+	1+3
SWITZERLAND	+	-	+	1+3
PORTUGAL	+	+	+	1+2+3
SPAIN	-	+	-	2
GREECE	+	-	-	1
ITALY	-	+	-	2
U. KINGDOM	+	-	-	1
AUSTRIA	+	-	-	1
BELGIUM	-	+	-	2
POLAND	-	+	-	2
SLOVÉNIA	+	-	-	1

Of the 12 countries represented, 8 were represented by experts who suited criterion 1 (8 in 12 = 66,7%), and the remaining experts suited at least criterion 2.

As for *the previous clinical experience*, an item that here is considered as a complement to the managing, supervision and evaluation of programs of opiate substitution evaluation, the analysis of Annex I - Characterization of the experts according to their clinical experience with opiate substitution, shows the following situation:

- 1- All the experts have already followed drug addicts in opiate substitution, namely with methadone (23 in 23 = 100%)
- 2- Median "Time of Experience in Substitution-



- Methadone* = *Group 5-15 years*
- 3- Median *“Time of Experience in Substitution - LAAM”* = *Group Less than 5 years, No answer = 65,2%*
  - 4- Median *“Time of Experience in Substitution - Buprenorphine”* = *Group Less than 5 years, No answer = 56,5%*
  - 5- Median *“Time of Experience in Substitution - Heroin / Morphine”* = *Group 5-15 years, No answer = 78,2%*
  - 6- Median *“Number of drug addicts included in the Substitution-Methadone program”* = *Group More than 15 people*
  - 7- Median *“Number of drug addicts included in Substitution-LAAM”* = *Group 5 to 15 people, No answer = 65,2%*
  - 8- Median *“Number of drug addicts included in Substitution-Buprenorphine”* = *Group 5 to 15 people, No answer = 56,5%*
  - 9- Median *“Number of drug addicts included in Substitution-Heroin / Morphine”* = *Group 5 to 15 people, No answer = 78,2%*

It is clear that although more than a considerable amount of experts involved in this study have a concrete and lasting experience with methadone (for the great majority, more than 5 years of experience, involving more than 15 people in treatment), the practice with the other substitution products, although significant, is slightly smaller: almost half of them have clinical experience with High Dose Buprenorphine (experiences with less than 5 years, and approximately 15 cases), approximately a third has experience with LAAM, (involving not more than 15 cases), and less than a fourth has experience with heroin and/or morphine (5 to 15 people, clinical experiences of variable length).

**b) Evaluation of the adaptation of the analysis instruments:**

The experts who participated in the study were the reference used to evaluate this item, as well as the next one. After the conclusion of the work, an evaluation questionnaire was given to all the participants, where they were asked about the quality of the analysis instruments, and they had to express their answers in numbers, in a scale from 0 to 20 points. By the way, it's important to recall, that the experts were the authors of the questions included in the questionnaire; however, only when it was being answered to they could contact with all the instruments, which were their own questions and the ones of all the other participants. On the whole, the answers obtained were the following:

*Content of the Questionnaire with Close Questions:*

Average	Minimum	Maximum	Most frequent Value (f=2)
12,6	8	18	12

*Content of the Questionnaire with Open Questions:*

Average	Minimum	Maximum	Most frequent Value (f = 3)
12,1	8	18	12



**c) Evaluation of the debates methodology:**

In this aspect, and as it has already been referred in the previous point, the evaluation questionnaire filled out by the experts after the end of the work generated the following results, in what the critical items for the evaluation of this field are concerned:

*Quality of the Discussions:*

Average	Minimum	Maximum	Most frequent Value (f = 3)
17	15	20	15 ; 18

*Quality of the Conclusions of the Groups:*

Average	Minimum	Maximum	Most frequent Value (f = 1)
15,2	10	19	

*Methodology:*

Average	Minimum	Maximum	Most frequent Value (f = 1)
14,8	10	18	



**d) Evaluation of the results:**

As it has been referred throughout this Exploratory Study, the results to be valued in an initiative of this kind are different from those of a classic evaluation study. Instead of trying to get a vision as exact as possible of the reality of the practices of opiate substitution in Europe (motivation through the effectiveness), this Study tries to highlight which areas of development of these practices will need larger theoretical-practical deepening, in order to contribute to the integration of the different realities prevalent nowadays in Europe in a coherent scientific-empirical model (heuristic motivation).

This general aim implies that in the analysis of the obtained answers, we value the questions where two types of statistical tendencies were verified:

- ***Low Level of Divergence:*** Recommendations with great importance for the practice, but of low heuristic saturation
- ***High Level of Divergence*** Recommendations for investigation, with high heuristic saturation, and causing no impact on the practice of the services

Following this analytical line of the work of the experts involved in this study, based on the instruments produced and on the methodologies used, the following subjects are pointed out:



**Map 3: Analysis of the Answers to the Questionnaires:**

<b>QUESTIONS</b>	<b>DIVERGENCE</b>
Administration of opiates of substitution exclusively by the health services	Low
Administration of opiate substitution by explicit request of the drug addict	High
There are contraindications for a substitution treatment with methadone	High
Methadone of low threshold only aims to reduce risks	High
The existence of exclusion criteria in a therapeutic program of substitution is positive	Low
Initial prescription of methadone only in specialized centres	Low
Initial prescription of high dose buprenorphine only in specialized centres	High
Control of high dose buprenorphine prescription to avoid black market / improper use	Low
Administration of substitution products by the pharmacist, under the supervision of a specialized team	Low
Administration of heroin controlled by doctors	High
Administration of substitution products by injection	High



<b>QUESTIONS</b>	<b>DIVERGENCE</b>
Substitution products have other therapeutic effects	Low
Agreement on doses of methadone above 140 mg / day	High
Controlled distribution of heroin and opiate substitution - the same practice.	High
Time to begin the evaluation of the evolution of a drug addict in substitution	High
Opiate substitution in Therapeutic Community	High
Impact of a substitution program: it reduces the use of other drugs and injecting, increases the frequency of the psycho-social support and the visits to the doctor	Low
Compulsory attendance of the psycho-social support for users of methadone programs	High
Compulsory control of urinary metabolites of drugs for users of all of the substitution programs	Low
Impact of substitution program in the psycho-therapeutic attendance	High
Similarity in the admission / exclusion criteria for the several substitution programs	Low



## ***V. CONCLUSIONS***

Although the Exploratory Study is meant, for the heuristic aims associated with it, for the search of the lines of the investigation to be privileged for the epistemological reinforcement of the theoretical models that sustain the intervention (in this case, the analysis of the divergence among experts), a first observation must be made about the questions where there was significant agreement among experts.

A great part of these subjects is related to well known characteristics of the products and opiate substitution programs, and they don't seem capable of controversy: the compulsory nature of urinary controls for research of drugs metabolites, the importance of a medical control in the beginning of the treatment, as well as in its supervision, the need for exclusion criteria exists, the importance of the participation of pharmacies in the substitutes' administration.

However, two points have generated consensus among the experts and for different reasons, those points must be moved to the part of these conclusions referring to the investigation lines to be developed in the future: the issue of the adhesion of the users of these programs to the other treatments they should be included in, because of the multiple problems that go with the drug addiction, (there is a contradiction with several other answers to similar questions that caused divergence), and the other therapeutic effects of the substitution products.



The questions that caused the greater divergence among experts can be organized in specific areas, according to the themes that motivate them:

- 1) Programs of Substitution themselves:
  - a) *Clinical aspects:*
    - Similarity of admission and exclusion criteria in several substitution programs (What makes their nature and clinical usefulness different?)
    - What are the contraindications for methadone?
    - Appropriate doses
    - (What are the other therapeutic effects of the substitution products?)
  - b) *Aims and Evaluation of the programs:*
    - The problem of the substitution with heroin - the same practice?
    - Substitution with intravenous products - yes or no?
    - Programs of methadone of low threshold - risks reduction and/or treatment?
    - How much time to significantly evaluate someone who's in a substitution program?
  
- 2) Relationship between the substitution programs and other therapeutic modalities, such as:
  - Substitution in Therapeutic Communities: yes or no?
  - Psycho-social support: compulsory or not?
  - Psychotherapy: positive or negative impact?



3) The roles of the Technicians and of the Users in substitution programs:

- Impact differences between the user's wishes in the beginning of a substitution program and the beginning of other therapeutic modalities?

Recognizing the evaluation made in this Study, regarding the representation of experts who participated in it, the validity of the used methodologies, and the results created with those methodologies, the Recommendations that come from it about the guidelines of the study and investigation to take place in the future, that contribute the most to the integration of the different practices of opiate substitution in a solid and coherent model are the following ones:



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## **VI. RECOMMENDATIONS**

1. There is an urgent need of a **deep and wide reflection on the aims of the programs** of opiate substitution. That reflection must be complex, that is to say, it should lean over **all the sanitary aims proposed for a particular population**, and only after can we understand which is the role of a substitution program to try to get to those aims. Creating substitution programs without including them in a strategy for global health is a risk (for the drug addicts, the professionals, and for the organization of the sanitation network), and that could cause clashing effects, creating paradoxical situations in the relationship of the drug addict with the network of cares that he/she needs.

1.1) Only after this reflection, is it possible to answer the **questions created by the possibility of using other products, namely the controlled administration of heroin**, as a possible means of improving the sanitary state of a drug addict, inserted in a specific social sanitation context.

1.2) On the other hand, only with a redefinition of the social sanitation situation of these programs will it be possible to promote, **with the drug addicts and with all the technicians working in them** (and it is wanted that there will be more and more, and from different disciplines), the full perception of the aims and of the usefulness and validity of these procedures, **facilitating the most appropriate attitudes for the adhesion of both parts to these methodologies**.



2. There is an evident need for **exhausting pharmacological investigation** on the properties of these substances, especially in order to explain their therapeutic actions, their tolerance and safety.

3. Under the clinical point of view, **the evaluation of the effectiveness of each of these substances, and of the differentiated effectiveness of each one of them**, according to the characteristics of the users or of specific sub-groups, is an urgent necessity. The politics of preferential administration of a certain substitution product (which have been practiced in most of the European countries, in some moment of their history), instead of a deep study of the effectiveness of each one of the products available to respond to specific problems, does not promote the possibility of the technicians being aware of new approaches to the problem, and it might ruin the possibility of significantly improving the care provided to the drug addicts.



## **ANNEX I**

### **LIST OF EUROPEAN PARTICIPANT EXPERTS / CHARACTERIZATION OF THE GROUP OF EXPERTS**

#### **FRANCE :**

- 1) Alain Morel - *Psychiatrist, Psychoanalyst, Director of Trait d'Union, Responsible in ANIT France of the Group of Studies about Substitution Opiate, Former president of ERIT*
- 2) Olivier Thomas - *Doctor, AMPT, Marseille*
- 3) Anne-Béatrice Grenouillat - *Doctor, CEDAT, Marseille*
- 4) Henri Guillet - *Psychologist, ESSONE Accueil, Evry*
- 5) Jean-Yves Noel - *Doctor, Center Chimène, Issy les Moulineux*

#### **GERMANY :**

- 6) Constanze Jacobowski - *Doctor, Clearingstelle fur Substitution - Artzkekammer Berlin, expert on Drug Addiction of the German government, Berlin*
- 7) Harald Wunderle - *Doctor, Augsburg*
- 8) Wolf-Dieter Hofmeister-Wagner - *Doctor, Bad Homburg*
- 9) Veronica Reisser - *Doctor, Café Fix, Commission for Substitution in Hessen, Frankfurt*

#### **PORTUGAL :**

- 10) Teresa N. Vicente - *Psychiatrist, Psychoanalyst, Director of the CAT Coimbra*
- 11) Alvaro Pereira - *Doctor, Director CAT Algarve*
- 12) Antonio Costa - *Psychiatrist, Responsible of Substitution Therapies in CAT Taipas, Lisbon*
- 13) Paula Brum - *Psychiatrist, Responsible of the Unit of Internment in CAT Taipas, Lisbon*
- 14) Olga Fortes - *Psychiatrist, CAT Cedofeita, Porto*

#### **SWITZERLAND:**

- 15) J.J.Déglon - *Doctor, Director of the Fondation Phenix, expert on Drug*



*Addiction of the Helvetic Confederation Government*

16) Martine Monnat - *Doctor, Lausanne*

**ESPANHA :**

17) Miguel Angel Torres - *Psychiatrist, Director of Unidad Alcoholismo y Toxicomanias, University Teacher, vice-president of SOCIDROGALCOHOL, Valencia*

**GREECE:**

18) Christos Kokkoris - *Psychiatrist, expert on Drug Addiction of the Greek Government, Athens*

**ITALY:**

19) Andréa Fuscone - *Doctor, Director of the Dipartimento delle Farmacodipendenze, Naples*

**UNITED KINGDOM:**

20) John Merrill - *MB ChB MRCPsych, - Psychiatrist, Chief Consultant of Drugs North West, Manchester*

**AUSTRIA :**

21) Gabrielle Fischer - *Psychiatrist, Investigator, University Teacher, Director of Drogenambulanz, UniversitatKlinik Psychiatrie, Wien*

**BELGIUM :**

22) Pascale Pierret - *Doctor, Projet LAMA, Brussels*

**SLOVENIA:**

23) Andrej Kastelic - *Doctor, Director of Centre for Treatment of Drug Addiction, belonging to the Coordination of Centre for Prevention and Treatment of Drug Addiction – Health Ministry*

**POLAND:**

24) Jan Flieger - *Doctor, specialist in drug addiction, Poznan.*



**CHARACTERIZATION OF THE EXPERTS ACCORDING TO  
THEIR CLINICAL EXPERIENCE WITH OPIATE  
SUBSTITUTION**

N = 23

***(TAKEN FROM THE RESULTS OF SPECIFIC  
QUESTIONNAIRE ANSWERED BY 23 DOS 24 EXPERTS -  
DATA OF DR. FLIEGER NOT INCLUDED)***

- Since how long ago have you been working with drug addicts?

Less than 5 years - 17,4%  
From 5 to 15 years - 39,1%  
More than 15 years - 43,5%

- Since how long ago have you been working with drug addicts in  
substitution programs?

- Methadone :

Less than 5 years. 43,5%  
From 5 to 15 years. 47,8%  
More than 15 years - 8,7%

- LAAM

Less than 5 years. 26,1%  
From 5 to 15 years. 8,7%  
More than 15 years - 0  
No Answer. 65,2%

- Buprenorphine

Less than 5 years .26,1%  
From 5 to 15 years. 17,4%  
More than 15 years - 0  
No Answer - 56,5%



-Heroin / Morphine:

Less than 5 years. 4,4%  
From 5 to 15 years. 17,4%  
More than 15 years - 78,2%

- How many drug addicts have you followed in:

- Methadone:

Less than 5 - 4,4%  
From 5 to 15 - 4,4%  
More than 15 - 91,2%

- LAAM

Less than 5 - 13,0%  
From 5 to 15 - 8,7%  
More than 15 - 13,0%  
No answer - 65,3%

- Buprenorphine :

Less than 5 -17,4%  
From 5 to 15 - 13,0%  
More than 15 -13,0%  
No Answer - 56,6%

- Heroin / Morphine :

Less than 5 - 8,7%  
From 5 to 15 - 4,4%  
More than 15 - 8,7%  
No Answer - 78,2%



## ***ANNEXE II***

### **QUESTIONNAIRES**

#### **Close questions**

1. Is it only the sanitary care system that must control the administration of opiate substitution?
2. Must the social care system control the administration of opiate substitution?
3. Can we prescribe the opiate substitution to all the drug addicts who want it?
4. Are there any contraindications to the prescription of a substitution treatment?
5. Do you think that using methadone in a low threshold has “only” a risk reduction aim?
6. In a therapeutic program of opiate substitution do exclusion criteria show expectations that (after being assumed by the user) bring any benefits for the treatment evolution?
7. Must the initial Methadone be only prescript by the specialized Centres ?
8. Must the initial LAAM be only prescript by the specialized Centres?
9. Must the initial Bruprenorphine be only prescript by the specialized Centres?



10. Must the Buprenorphine prescription be controlled to avoid the development of a black market?

11. Must the Buprenorphine prescription be controlled to avoid a misuse (intravenous use)?

12. Is it advisable to allow the administration of substitution opiates in the chemistry shops under the surveillance of the chemist and of the therapeutic team?

For the methadone  
For the buprenorphine  
For the LAAM

13. Do you agree with the free and controlled administration of heroin to heroin addicts?

14. Do you agree with the heroin prescription under medical supervision?

15. Do you agree with the intravenous substitution?

16. Do the substitution products have therapeutic virtues, besides their substitution function?

17. Do you agree with doses of more than 140 mg / day of Methadone in some cases?

18. In your opinion which is, from the three substitution treatments, the most chosen by the patients?

Methadone  
LAAM  
Buprenorphine



19. In your opinion which is, from the three substitution treatments, the most chosen by the doctors?

Methadone  
LAAM  
Buprenorphine

20. In your opinion which is, from the three substances, the one that is most sold in the black market?

Methadone  
LAAM  
Buprenorphine

21. According to you, is the buprenorphine (Subutex (®)) a good substitution treatment?

22. Must we present the buprenorphine on a non-intravenous variety?

23. Do you agree with the possibility of LAAM given at the users' domicile?

24. Are there any contraindications to the prescription of a substitution treatment?

25. Opiate substitution (Methadone, Buprenorphine, LAAM) vs controlled heroin distribution - same practice?

26. After how much time is it possible to make a relevant clinical evaluation of the evolution of someone under a substitution program?



Since the beginning      After \_\_\_\_\_ months in the  
program

27. Do you agree with the opiate substitution in a therapeutic  
community?

YES, in all the communities

NO

YES, but only in communities that are specially meant  
for this purpose

28. From your experience which is the impact of a substitution  
program on its users in what refers to:

*Using other drugs:*

Reduction              Growth              Same Situation

*Using an intravenous way:*

Reduction              Growth              Same Situation

*Using a condom:*

Reduction              Growth              Same Situation

*Medical attendance:*

Reduction              Growth              Same Situation

*Involvement in the psycho-social life:*



Reduction                      Growth                      Same Situation

29. Are you in favour of the Methadone programs of a low threshold, that is to say with no demandings of regular methadone use or therapeutic project more or less at a long term?

30. Having the maintenance methadone programs been also developed to protect against the risks related to injections and illegal acts, do you think that it is acceptable to stop the methadone treatment of a patient who uses intravenous cocaine everyday?

31. If one of your clients under a LAAM maintenance became pregnant what would you do?

- Continue LAAM administration
- Maintenance with methadone
- Maintenance with Buprenorphine

32. Is the buprenorphine suitable for pregnant woman?

33. Would you allow breastfeeding in a mother maintained with buprenorphine?

34. Do you have an idea of your methadone patients who died?

Cause of death \_\_\_\_\_

35. Do you have an idea of your LAAM patients who died?

Cause of death \_\_\_\_\_

36. Do you have an idea of your buprenorphine patients



who died?

Cause of death \_\_\_\_\_

37. Do you consider the psycho-social support an obligation for the treatment with

Methadone:

LAAM:

Buprenorphine:

38. Do you consider the psycho-therapeutic support an obligation for the treatment with Methadone:

LAAM:

Buprenorphine:

39. Do you consider an obligation the drugs metabolites control during the treatment

with Methadone:      which ones \_\_\_\_\_

with LAAM:            which ones \_\_\_\_\_

with Buprenorphine:    which ones \_\_\_\_\_

### **Open questions**

41. Taking into account your experience, present three differences between a psychotherapy in a drug-free program using Methadone, LAAM or Buprenorphine :

42. In your opinion, which are the three main indications for a substitution treatment?

43. According to you (from the patient's point of view) which



are the three most significant elements for the success of a substitution treatment?

44. According to you (from the prescription modalities point of view) which are the three most significant elements for the success of a substitution treatment?

45. According to you which are the three most significant elements for the success of a substitution treatment with methadone?

46. According to you, which are the three most significant elements for the success of a substitution treatment with buprenorphine?

47. According to you which are the three most significant elements for the success of a substitution treatment with LAAM?

48. In your opinion, which are the 3 main contraindications not to prescribe a substitution treatment with Methadone to a heroin addict?

49. In your opinion, which are the 3 main contraindications not to prescribe a substitution treatment with Buprenorphine to a heroin addict?

50. In your opinion, which are the 3 main contraindications not to prescribe a substitution treatment with LAAM to a heroin addict?

51. What about the heroin used as a “substitution” therapeutic in some European countries?

52. In your opinion what are the 3 most important aspects



of the “contract” established with the patient before a Buprenorphine treatment (Subutex)?

53. In your opinion what are the 3 most important aspects of the “contract” established with the patient before a Methadone treatment?

54. In your opinion what are the 3 most important aspects of the “contract” established with the patient before a LAAM treatment?

55. In your opinion, how many patients (percentage) in the opiate substitution program are willing to achieve permanent abstinence during the first two years of the treatment and why?

56. Indicate three benefits (if there are any) that you find in the combination buprenorphine-naloxone (tablets).

57. Which are the three most important criteria to banish someone from the substitution program?

58. How can we take into account the person, body and soul in the substitution treatments?

59. Which are the three main difficulties found in the Methadone program?

60. Which are the three main difficulties found in the Heroin program?

61. Which are the three main difficulties in the Buprenorphine program?



62. Which are the three main difficulties found in the LAAM program?

63. Which are the three main difficulties found in the Morphine program?

64. What is the ideal length of a substitution program to reach the abstinence and the organization of the individual?

65. Treatment with Methadone:

Indicate 3 admission criteria

Indicate 3 exclusion criteria

Treatment with LAAM :

Indicate 3 admission criteria

Indicate 3 exclusion criteria

Treatment with Buprenorphine:

Indicate 3 admission criteria

Indicate 3 exclusion criteria

Treatment with heroin:

Indicate 3 admission criteria

Indicate 3 exclusion criteria

Treatment with morphine:

Indicate 3 admission criteria

Indicate 3 exclusion criteria

66. What do you usually do with your patients who have



an important somatic problem (permanent ulcerations, endocarditis, AIDS...), who do not correspond to the methadone program standards, continue to use heroin and cocaine and must go regularly to the hospital because of their health condition.

Name your three most usual attitudes.

67. What do you do when a patient in a methadone substitution treatment starts a regular use of cocaine?

Name 3 attitudes.

