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How to treat the treatment system

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Summary

The ancient Greek maxim "Know thyself" also applies to health care systems, which cannot adequately cure the patients if they cannot cure themselves. They should be able to identify and repair their own shortcomings. Treatment should be available for all patients who need it and there should be no waiting-lists. To reach this availability primary care physicians should provide these treatments. Regulations should be eased, because excessive regulations and controls are counter-productive. They are a barrier to treatment and they increase the risk of death for patients.

Key Words: treatment system; treatment issues; critics

The ancient Greek maxim "Know thyself" also applies to health care systems, which cannot adequately cure the patients if they cannot cure themselves. They should be able to identify and resolve their own shortcomings.

Let us imagine a medical fiction: drugs against hypertension would be insufficiently available, patients could only have limited take-home doses, and failure to respect their diet would be sanctioned by the discontinuation of treatment. This would lead to the emergence of a black market. Some patients would be tempted to sell their drugs to make easy money they would spend in excessive food and drinks, which would increase their morbidity and mortality. People excluded from the treatment system would try to treat themselves with drugs bought on the black market. Reduced to self-medication, without supervision, they would also suffer from higher morbidity and mortality.

1. A chronic relapsing disease

This absurd system is however considered normal in the treatment of opiate dependence. In most of the world, the availability of opiate agonist treatment is significantly below requirements. Hence, the black market for medicine, the use of illicit substances, overdoses, injections in dire conditions and infections proliferate. This creates a vicious circle where the lack of treatment makes the treatment more difficult.

The general medical ethics is to move as soon as possible from diagnosis to treatment, in order to

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reduce human suffering. There is no reason to do otherwise with illicit drugs' users. Fifty years of research have shown that opiate addiction is a long-term problem marked by relapses, that is to say a chronic relapsing condition. As with any condition of this type (diabetes, hypertension, etc.), opiate dependence requires most of the time a long-term treatment with adequate dosage of opiate agonist treatment like buprenorphine (Subutex, Suboxone) or methadone.

2. Effectiveness of treatment

Yet this process is far from being considered as normal everywhere. What is the problem? It is not a problem of diagnosis of opiate addiction, which is quite simple. It is not either a therapeutic challenge because appropriate treatment is easy to carry on. The problem is in the transition from diagnosis to treatment, and more specifically in the barriers that society opposes to opiate agonist treatment.

To better understand this phenomenon, consider the natural history of a heroin addict. The first stage is a period of occasional use without dependence, which can be shorter or longer, depending on the personal history and the environment. Dependence appears there, that is to say the need to use heroin every day. The dependence can last one to five years before a heroin addict makes an initial request for care. The treatment itself will take between three to twenty years (or more), depending on the personality and the environment.

Heroin addiction is a double dependence: dependence to a substance and to a lifestyle, to an environment. This is why there are two strategies for therapeutic approach. One is to give medication withdrawal for a few weeks, then followed by "substitution environment", (i.e. residential post-cure) of six months to a year at least. Observation shows that at a given moment not more than 5 % of active addicts are willing to follow this pathway. Another therapeutic approach leads to a higher recruitment rate: the treatment with " substitution drugs " which are delivered on an outpatient basis and do not require removal from the environment. When this treatment is sufficiently available, about 70% of active heroin users are willing to enter.

The retention rate in residential treatment (" substitution environment ") is at best 30 %, while it reaches easily 70% with substitution drugs. The efficiency rate of the first processing system is around 5% x 30%

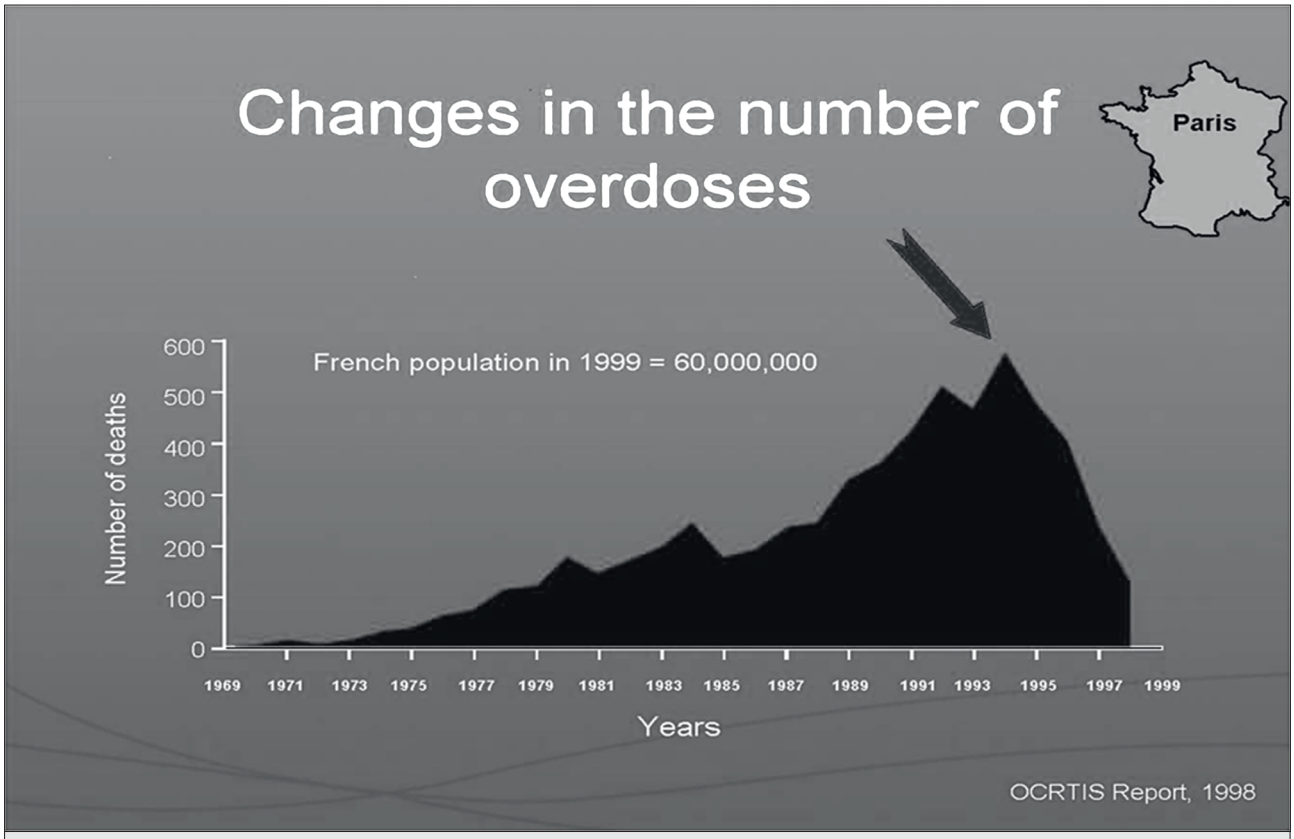

Figure 1: Mortality from overdose in France

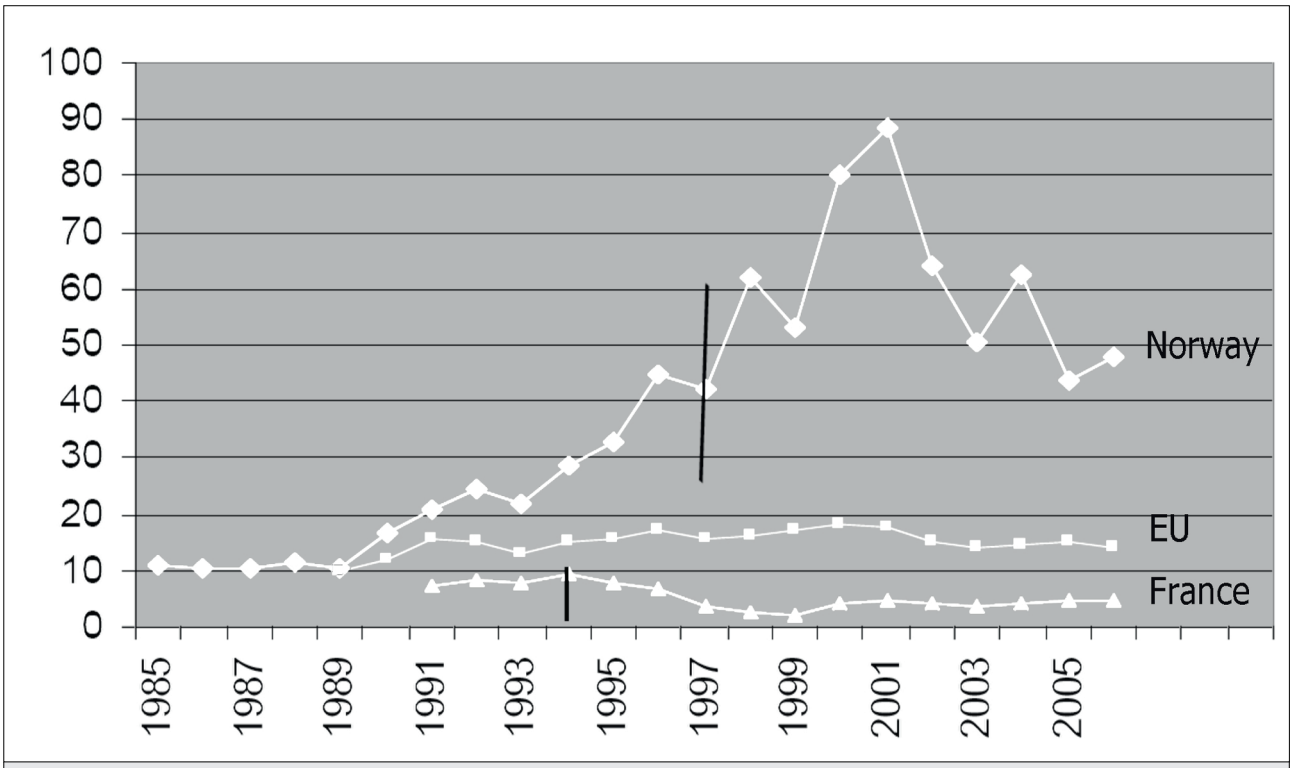

Figure 2: Drug-related mortality in Norway, France and the European Union. Vertical lines: rapid increase of opiate agonist treatment in France (1995). Beginning of the "medically assisted rehabilitation treatment" in Norway (1998) [3].

= 1.5% of all heroin users, while the second system reaches 70% x 70 % = 49 %. Both systems have their necessity and their indications, but their social impact is obviously quantitatively different.

3. Realistic and utopic approaches

In a realistic perspective there should be no gap between treatment supply and demand, in order to avoid waiting lists. Access to treatment should be limited only by the cost/effectiveness ratio. In this perspective, in Belgium and France, for example, 85 % to 90 % of treated opiate addicts are in office-based treatment and 5 % to 10 % in outpatient clinics. 90 to 95% of patients are treated with opiate agonist treatment, buprenorphine (Subutex ®, Suboxone) or methadone. A small number of patients are staying in residential aftercare centers.

On the contrary, some countries have chosen an utopic perspective. They pursue a dream of perfection regardless of the accessibility of care. For example, the Norwegian Health Department considers that Norway has the "most expensive treatment system" and "also one of the best system of the world" [4]. But if one compares the realistic and the utopic approaches based on a key criterion, namely the number of lives saved, we see that the number of deaths related to drug use is much higher in the utopic system.

In France, the dramatic increase in access to opiate agonist medical treatments (primarily Subutex) has led since 1995 to a sharp drop in the number of drug-related deaths.

On the contrary, the Norwegian system causes a drug-related death rate 10 times higher than the European Union average.

The difference is related to the fact that in the Norwegian "medically assisted rehabilitation" system, the provision of care is grossly inadequate compared to the demand. This induces the death of patients waiting for treatment. Norwegian studies have yet demonstrated that patients receiving buprenorphine, while they wait for a more comprehensive treatment, die less than those receiving a placebo (how surprising!) [6]. Despite these observations the Norwegian system continued to prescribe "time-limited buprenorphine replacement therapy" with a high mortality rate: in a study 5 out of 75 patients (6.6%) died in 24 months [5]. Another study has shown that the mortality rate was 1.9% per year while waiting for treatment and 0.4% during treatment [1].

Other countries offer insufficient access to opiate agonist treatment, despite its effectiveness. This can be explained by the fact that the treatment of drug users is just an option, that some countries did not

take yet or do not completely assume. The opposite option is expressed in the words of a responsible of public health in Russia, where opiate agonist treatment is totally banned: "You call addicts 'patients', we call them lost citizens…"

In countries who prefer to hide drug addiction problems, drug deaths contribute to this goal. However, addicts who disappear from society reappear in the statistics. This is why the Norwegian researchers have to recognize that "Norway shows a high mortality in drug statistics of the European Monitoring Centre for Drugs" [2] .

4. How to cure the system

Such awareness could help to improve health care systems. In order to do this, one must first establish a diagnosis. It could be based on three main symptoms:

1. Availability of opiate agonist treatment
   a. Proportion of patients in treatment
   b. Treatment options
   c. Flexibility or rigidity of supply
   d. Stigmatization
2. Waiting-time before treatment
3. Existence of "open drug scenes".

Treatment should be available for all patients who need it and there should be no waiting-lists. To reach this availability primary care physicians should provide these treatments. Regulations should be eased, because excessive regulations and controls are counter-productive. They are a barrier to treatment and they increase the risk of death for patients.

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