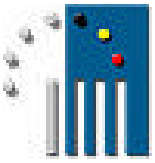

FEDERAL SCIENCE POLICY

Substitution treatments in Belgium

Development of a model for the assessment of different types of services and patients

Summary

Research Programme on the Federal Policy Document on drugs

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1. Introduction

The present publication is the outcome of a research programme supporting the Federal Policy Document on drugs of the Federal Science Policy, and it deals with the evaluation of the organisation and the practice of the substitution treatments for patients addicted to opiates in Belgium.

Two university teams have been entrusted with this research: the *Laboratoire de Psychologie Médicale, d'Alcoologie et d'étude des Toxicomanies* of the Université Libre de Bruxelles (directed by Pr. Isidore Pelc), and the *Afstudeerrichting Gerechtelijke Geestelijke Gezondheidszorg* of the Katholieke Universiteit Leuven (directed by Pr. Joris Casselman). The research was split up in two stages: the first stage from August 2002 to September 2003, and the second stage from October 2003 to October 2004. The first stage focused on the feasibility of the use of classic means of evaluation of the treatments. The second stage focused mainly on the elaboration of an evaluation system adapted to the specific context of these treatments in Belgium. Simultaneously the research brought into light a number of important questions about the evaluation of treatments situated on the cross lines between the psychological, social and medical fields.

2. Context of the research

Today, methadone is clearly the substitution substance by excellence in the treatment of addiction to opiates in Belgium, as well as in most of the countries where these treatments are applied. However this treatment has been strongly countered before being able to prevail. When the first Belgian medical experiences took place in this field, at the beginning of the 1980's, this practice was still forbidden by the Law of 1921 because it was considered to maintain addictions. The 1980's have witnessed a major medical battle on the administrative and legal fields, between the supporters and the distracters of the treatments of substitution. Finally, this conflict led to a compromise; a Conference of Consensus, organised in Gent in 1994. The Justice agreed not to apply the law when substitution treatments were involved, and from then on, relied on medical authorities to apply the recommendations of the Conference of Consensus. In this period of judicial tolerance, the practice of substitution treatments knew a large scale development, booking undeniable success in terms of Public Health. In fact, from this moment on, any practitioner strictly complying with the recommendations of the Conference of Consensus could treat addicted patients with substitution treatments. In 1995, the Federal Government adopted a *"Programme d'Action Toxicomanie-Drogue"* strongly recommending the creation of low thresholds care-centres, the *Medical-Social Open Centres for drug users* (MSOC), where the practice of substitution treatments was promoted as a privileged method. At last, in 2002, a law modifying the law of 1921 legalised the practice of these treatments.

This historical and judicial context makes clear why Belgium has been a fertile soil for the development of all kinds of different approaches, counting many different field actors practising ambulatory substitution treatments, such as:

1) physicians practising in private offices;
2) physicians organised in assistance networks;
3) physicians working in ambulatory institutions specialised in substitution treatment for addicted patients (called “session centres”);
4) physicians working in the Medical-Social Open Centres for drug users (MSOC).

Our evaluation work regards the strategic interest of substitution treatments as one organisational process among others within the range of existing treatments for addicted people. More concretely, it implies taking into consideration the profile of the patients accessing these treatments in the different types of institutions or offices where these treatments are applied, wondering what patients expect and what they receive, asking ourselves what their own practices mean to the physicians and how these practices fit, homogeneously or not, the global process of assistance to the drug addicted.

During the first stage of the research, from August 2002 to September 2003, the research teams attempted to implement a set of measures based on instruments validated by the scientific literature and internationally recognised. We mainly refer to the use of questionnaires *Addiction Severity Index (ASI)* and *Qualité de Vie Subjective (QUAVISUB)*. However, it appeared that these questionnaires were not totally adapted to the organisational conditions of the institutions practising the treatments in Belgium. Several elements hindered this method, particularly the great variety of objectives and practices in terms of substitution treatments that was obliterated by these instruments.

During the second stage of the research, a new questionnaire has been made and called *Substitution, Expectations, Qualité de Vie (SEQ)*. It has been used in the course of two sessions, in Wallonia, Brussels and Flanders, by 424 patients in treatment by more than 50 physicians. Furthermore, the approach of the variety of objectives and practices of the substitution treatments has been deepened by organising encounters with physicians. We met about fifty physicians in different places of intervention. Finally, out of the results of our research conclusions were drawn and recommendations were formulated to the authorities.

3. Quantitative part

3.1. Objectives and means

The general goal of the quantitative part of the research was to approach and explain the diversity of the practices in the field of substitution treatments. In fact, one could suppose that this diversity could be explained by the regional contexts (Wallonia, Brussels, Flanders), the different types of physicians, their own techniques, or practices depending on the type of patient. Therefore, the objectives of the quantitative part are:

a. to statistically objectify the observations qualitatively demonstrated in the first stage concerning the *diversity of the practices*;
b. to bring up the *specific objectives of the treatments*, for the physician as well as for the patient of our sample, and also the converging aspects of these two kinds of actors;
c. to attempt clarifying the *indicator of the Quality of Life, health, "distance" to abstinence*;
d. to show *other significant indicators* of the progress of the treatment;
e. to *test the recommendations of the Conference of Consensus* to the frame of the practices of our sample;
f. to establish variables *sensible to rapid evolution changes*, particularly by new patients, with a test-retest after a couple of month.

The quantitative research has been done thanks to the questionnaire especially elaborated for the purpose of this research: the *SEQ*. It is composed of two parts: a *Patient's Questionnaire* –for the patient– and a *Technical Form* — for the prescribing physician.

The *Patient's Questionnaire* contains 3 parts : the first one regarding the patient's expectations of the treatment, a second one concerning the type of treatment and the habits of drug use, finally a third part measuring the subjective Quality of Life of the patients.

The *Technical Form* is divided in two parts: one part dealing with specific technical aspects of the treatment (type and doses of medication, substitution substances, frequency of the follow-up, compliance with the rules, place of administration of the substance and plan of treatment). The second part contains a list of possible goals for the treatment, to which the physician can attribute a level of importance.

3.2. Sample of patients

The patients were recruited by the physician practicing the substitution treatment. We made a distinction between the physicians working in private offices, and the physicians working in institutions. The institutions and physicians have received a financial compensation for the work load represented by their participation to the research. The institutional partners were: the MSOC of Charleroi, Brussels, Gent and Flemish Brabant, and the *Projet LAMA* (Brussels). The other partners were private physicians in Brussels, Flanders and Wallonia, either recruited in Medical Houses either through the ALTO network (Brussels and Wallonia), or agreed physicians in the field of substitution treatment (Limburg).

During the two sessions, we have collected the following questionnaires:

TABLE 1 : NUMBER OF QUESTIONNAIRES COLLECTED PER SESSION, PER REGION AND PER TYPE OF PHYSICIAN

	Brussels (Fr.)		**Charleroi-Wall.**	
	Session I	***Session II***	***Session I***	***Session II***
Private Off	*9 physicians*		*18 physicians*	
Number of ques.	40	11	103	5
Institutions	*2 inst. – 15 physicians*		*1 inst. – 5 physicians*	
Number of ques.	89	68	36	0
TOTAL	*24 physicians*		*23 physicians*	
Number of ques.	129	79	139	5
	208		144	
Total session I : 268				
Total session II : 84				
TOTAL : 352				

	Flanders	
	Session I	***Session II***
Private Off	26	0
Institutions	29	0
TOTAL	55	0

Total Session I : 323
Total Session II : 84
TOTAL : 407

3.3. Used substances

The great majority of patients of the sample were treated with methadone, only six of them were treated with buprenorphine. We noticed great differences in the dosages: from 1 to 400 mg. The patients generally declared themselves satisfied. There is no significant difference between the regions or type of physicians. The doses were significantly higher in the Brussels's institutions and in the Flemish private offices. We also observed a difference in the dosage according to the plan of treatment: the patients aiming at a progressive withdrawal received significantly less methadone than patients in substitution treatment *stricto sensu* or maintenance treatment. It is probable that a patient apparently sicker will be administrated higher doses.

43% of the patients of the sample take heroin, also occasionally, and 15% daily. The daily users are treated since less than 6 months. Methadone treatment contributes rather rapidly to a decreasing amount of daily users. Most of the patients take other prescribed psychotropic medication: painkillers (66%) sleeping pills (44%) anxiolitics (28%) and anti-depressives (26%).

Flemish patients globally express a higher level of satisfaction concerning the use of these medicines.

3.4. The treatment framework

The physicians in institutions tend to meet with their patients once a week, while physicians in private offices generally meet once every two week. Patients treated for more than six months are followed more regularly. The great majority of patients are considered as regular (93%) and complying with the rules of the treatment (95%). This high level of regularity and respect of the rules is probably linked to the selection. A small half of the patients take their medication at the pharmacist's, the other half manages the treatment autonomously.

Concerning the plan of the treatment, progressive withdrawal is frequently observed by patients being treated since less than six months, and maintenance treatments by patients being treated for more than 24 months. Abstinence is a more important goal for patients in progressive withdrawal for more than 24 months, for the practitioner as well as for the patient himself. On the other hand, the patients in a maintenance plan of treatment are less regular, have less respect for the rules, are followed for a longer time and use higher doses of methadone. The physicians pay more attention to the harm reduction goals for these patients. For them the objective of *"controlling the use of heroin"* is a priority.

We found thus a coherent link between the type of patient and the plan of treatment. However one can ask himself if the patients' characteristics do not influence his classification which then determines the plan of treatment established by the physician.

3.5. The objectives of the treatment

From the physician point of view, the most important objective is to *"maintain contact with the system of assistance"*, followed by *"the improvement of the self-image"*. The objective of abstinence is of little importance for the physicians working in Brussels's institutions and in Wallonia, but very important to the Flemish physicians in private offices. From the patient's point of view, the persons treated in private offices in Brussels and Wallonia give less attention to the objective of abstinence than the patients treated in private offices in Brussels. But on the other hand, and compared to patients treated by other types of physicians, patients treated in private Flemish offices give more priority to the *"control of drug use"*.

The correlations between the objectives allow us to distinguish 4 types of dimensions: a *"psychological" dimension, a "secure" dimension, a dimension "linked to the substance"* and a *"social" dimension.* This last one is considered to be the most important, while the *"secure" dimension* is considered to be the less important.

The objectives of the "psychological" and "social" dimensions of the patients are not always clear to the physicians. Furthermore, physicians find the "secure" dimension the least important, but when patients give this dimension priority they feel in full accordance with them. On the opposite, the physicians' preoccupations about the patients' health find little echo with them.

3.6. The trajectory of the patients

38% of the patients are in contact with their present physician since less than a year, and 68% are followed up by their present physician since less than 4 years. The physicians in private offices have known their patient for a longer time than the physicians in institutions. The physicians in Flemish institutions seem to all follow their patient since less than 6 months. 34,5% of the patients are given a substitution treatment since less than a year. However 46% of the have already been treated in the past.

The average patient had his first contact with an opiate at the age of 19. He became dependant at the age of 22 and had his first substitution treatment at the age of 25. An average 6 years separate the first contact with an opiate from the first substitution treatment. These contact ages for dependence or for the first treatment do not seem to have much influence on the type of treatment. On the contrary, the duration of the treatment seems more determining: the longer the treatment the more it slips away from the short term objectives of abstinence to move towards long term maintenance objectives.

3.7. Quality of Life

From a general point of view, the Quality of Life of the patients is significantly worse than the one of the Belgian population in good health, of the same age and same gender and assessed by the same instruments (SLDS). Flemish people express more satisfaction than the others. This does not mean that all drug addicted have a bad Quality of Life: in fact 130 patients out of 295 reached the threshold of a satisfactory Quality of Life.

3.8. Second session

The test-retest analysis shows common changes, such as the length of time between the appointments and a more autonomous management of the dispensing, for all partners and without distinction of the duration of the treatment, or without considering the therapeutic centre. The doses of methadone of the patients being treated "for 24 months of less" were a significantly adjusted between the two tests. Thus, it seems that we could distinguish three stages in the evolution of substitution treatment, according to the duration of treatment. The **first stage** concerns the **first six months of the treatment** of a patient. The frame of the treatment is clearly more strict (daily dispensing, importance of complying with the rules...) and the objectives are more focused on a relatively short-term abstinence. In the **second stage**, **more than six months and less than 24 months,** the self-management of the treatment is more important, and, even if the treatment seems oriented toward abstinence, the goal seems to be postponed to the long term. Finally, in the **third stage, starting after 24 months,** the importance of the frame diminishes, and the objectives of harm reduction gain more importance as they fit in a logic of maintenance. It is however important to note that such an evolution cannot only be due to the patient's own evolution factors, but also to the way the physician perceives the patient.

3.9. Conclusions

1. Patients' compliance: the great majority of participants (93%) can be considered as respecting the **rules of the treatment**. However, we do not know if this reflects the general attitude of all patients or if this is inherent to the selection of our sample.

2. Great diversity of practices: statistics confirm the great diversity of practices and the independence of the variables linked to the patients, to the treatment or to some characteristics of the patient's problems and the type of treatment he receives. For the patients, *contacts with the care givers* and *methadone as a medication* are the most important elements of the treatment, independently from the region, type of practitioner or place of the treatment. For the physicians, the reduction of criminal acts is an objective of the treatment with little importance.

At the regional level: two opposite *ideal-types* can be distinguished: Flanders on the one hand, and Brussels on the other hand; Wallonia places itself at the intersection of the two other regions. The Flemish patients are younger and treated since a shorter time. They use more often heroin and alcohol. They also are more satisfied of their Quality of Life. Methadone delivery is more controlled (offices / institution / pharmacist). Physicians pay less attention to the different objectives of the treatment – especially compared to Wallonia. The opposite description can be used for the region of Brussels.

At the medical level: in private offices, patients are treated for a longer time, with longer length of time between appointments, they are very regular and in most cases, this is their first treatment. Abstinence is an important goal, and methadone doses are smaller. The opposite description can be applied to the institutions where patients give more importance to urine tests and the social assistant.

3. The dimensions of the treatment and the objectives: Concerning the objectives of the patient we can distinguish four dimensions: a *psychological dimension*, a *social dimension*, a *secure dimension* and a *dimension linked to the type of substances*. The correlations between the objectives of the patients and the objectives of the physicians are very good when the patient chooses either the substance dimension either the secure elements.

They spread on the *"social"* dimension: the correlations are stronger when the patient chooses very concrete objectives such as *"find a satisfying job again"*. They are a lot weaker when regarding abstract objectives such as *"being able to realise my plans"* or *"being more available"*. At last, the correlation is particularly weak concerning strictly psychological preoccupations. Generally, autonomous dimensions do not strongly show among the objectives of the physicians, except for the dimension "linked to the substance" the "secure" dimension and a dimension "other objectives".

4. Quality of Life – Abstinence – Health: These three indicators distinguish different profiles of patients and different profiles of treatments. Reaching these objectives during the treatment is not exceptional; 46% of the patients have withdrawn from "hard" drugs, 44% consider that they have a good Quality of Life and 42% consider themselves in good health. These three objectives are related: Quality of Life, health, and abstinence do generally go together despite the fact that we cannot define a chain of causation.

5. New patients – Old patients – Long-term patients: It seems that we can distinguish three stages in the evolution of the substitution treatments, according to the duration of the treatment. For *new patients*, treated for less than six months, the frame of the treatment is clearly more strict (daily dispensing, importance of complying with the rules...) and the objectives are more focused on short-term abstinence (progressive withdrawal). For *patients in treatment* –between 6 up to 24 months of treatment– the self management of the treatment is more important and, even if it still seems to be focusing on abstinence this goal is sliding towards the long term. Finally, for *long-term patients* –being treated for more than 24 months– the importance of the frame fades and the goals of *harm reduction* gain more importance, as it fits in logic of maintenance. However, it is important to note that such an evolution can only be due to the patients' own evolution factors, and to the way the physician perceives his patient. In the sample, one can start a treatment at any age, but the later one starts his first treatment, the longer this treatment will last. This brings into light the chronic aspect of this problem.

6. Controls: The urine controls are considered as more important to the patients treated in institutions, and also for patients either in a plan of withdrawal, or where the objective of abstinence appear to be important. There is a negative correlation between the methadone doses and the importance of these controls. On the contrary, this objective is less important to patients in a plan of maintenance, and in private offices. The importance of the rules is particularly pointed out by patients aiming at a complete abstinence. Finally, new patients receive more methadone, either in a private office, either in an institution or at the pharmacist.

7. Variables that could be eliminated: Some variables are not related to parameters of the treatment or of the patient. It concerns on the one hand, background information about the patient's path (age of the first contact with drugs, age of dependence, age of the first request for help, age of the first substitution treatment), and on the other hand, information about the habits of heroin use.

4. The qualitative part

Through the qualitative approach, we intend to: 1) obtain information about the diversity of the practices in terms of substitution treatments, 2) obtain information about the diversity of objectives related to these treatments, 3) set up a context of interpretation of the quantitative part and, maybe, 4) distinguish practical indicators of measurement of the evolution of the treatments and of the patients (focusing on the efficiency of the treatments).

4.1. Methodological reminder

TABLE 2: NUMBER OF PHYSICIANS INTERVIEWED FOR THE QUALITATIVE PART

	Institutions	**Private Offices**	**Total**
Brussels	15	9	*24*
Wallonia	5	18	*23*
Total	*20*	*27*	*47*

We individually interviewed for approximately one hour each of the physicians practising in private offices. For the physicians working in institutions we organised group sessions of approximately two hours according to the method of the *Focus Groups*.

We remind the reader that, the objective of an interview is to obtain the opinion of a person, either because this person has a specialised knowledge in a certain field (for example an expert), either with a view to prepare a more elaborate approach implying gathering personal information, or prior to a confrontation or mediation when it is important for each side to be able to confidentially express an opinion. The interview is only a process of gathering information, and as such, is only the subject of analysis in an enlarged context. The aim of this approach is mainly to have access to a personal truth of one's own experience with its own accents and subtleties. The interview takes place in the physician's office. They have been worked out as "listening" interviews, with few context notes where important sentences have been written down. The interviews are enriched with a context analysis and the unsaid (non-verbal expressions, mimics…). As a validation process, the text of the analysis was sent to the interviewed physicians who had the occasion to express an opinion about it. Their remarks have been included in the final analysis.

The *Focus Groups* are organised for individual participants (who only speak for themselves). The objective of these *Focus Groups* is to bring into light a range of opinions about a central question. The *Focus Groups* are reunions of participants coordinated by an animator, and lasting approximately two hours. As a validation process, the text of the analysis was sent to the participants who had the occasion to express an opinion about it. Their remarks have been included in the final analysis.

The qualitative data has been collected and registered by aggregation to certain number of key themes.

4.2. General description of the types of physicians

4.2.1. Physicians in private offices

The physicians working in private offices have a very restricted amount of patients following a substitution treatment. The consultations dedicated to this type of patients constitute the minor part of their work. Most of the physicians declare not willing to be considered as "specialised in drug addiction". Some justify this choice by the workload, other by their conception of general medicine which vocation is to assist and follow suffering patients with chronicle pathologies. The great majority of the physicians working in private offices have a rather negative perception of the consultations in institutions; *"it must be particularly unmanageable"*. Physicians in institutions have the inverted mental representation.

As for the majority of the clinical actors with their patients, there is a mutual adaptation between the medical actors and the patients that make the patient expect the physician to be able to meet his requests, and likewise, make the physicians see their patients through his expectations of what this type of patient is. This mutual adaptation happens mainly during the first contact. Although physicians mostly consider the drug addicted as undisciplined and disturbing, some physician's point of view is based on more relativism: *"Finally, they* [the drug addicted patients] *are very disciplined compared to other pathologies (arterial tension, diabetics…), the patients* [drug addicted] *do come to their appointments, no particular problem . There are more problems with alcoholic or psychotic patients "*.

We can thus conclude that the first appointment determines the setting of a frame of therapeutic relations. Some physicians declare explicitly setting this frame on purpose, and are conscious of the fact that this approach is potentially therapeutic. For the majority of the physicians, setting a frame does not fit in a strictly therapeutic logic but aims at establishing the conditions of a relatively comfortable follow up. The objective of the frame is the control of the conditions of the relation. Finally, for some physicians, establishing a frame does not seem to be a conscious of an important approach. They have a minimalist perception of their role: they task is to follow a suffering patient, with no intention of acting on the cause of the suffering.

4.2.2. Physicians in institutions

The institutional physicians that we met were working in the MSOC of Brussels and Charleroi (*Diapason*), and in the *Projet LAMA* (Brussels). On the opposite of what happens in private offices, establishing a therapeutic frame is globally the task of the institution, and not the physician himself. Even when the access to a substitution treatment is facilitated, the patient first meets other clinical actors before meeting the physician. The institutional physicians express a certain feeling of relief by being able to rely on other clinical participants for the management of the frame. On the opposite of what physicians in private offices assert, they have a relatively negative image of treatments where such a structure does not exist, for example in private offices.

4.3. The relation to the substances (drugs, medication) – the objectives of the treatment

4.3.1. The drugs, the opiates

On a principle level, all physicians agree on the fact that understanding drug addiction cannot be limited to dependence problems, or to a "simple" matter of consumption control, but that other aspects should be taken into account such as psychological or social aspects. For a majority of physicians, these aspects are perceived as determining. In the same line of logic, the physicians agree on the fact that a problematic drug use is always the consequence of other pre-existing problems. The practices and underlying mental representations of these practices do however converge with these principles.

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We can distinguish three principal ways of understanding the problem as such. A first way is when drug addiction is essentially defined by the drug use, namely illicit psychoactive substances; the second way is when the relation of dependence to the substance is determining, and the third way is when drug addiction is perceived as a problem with a pre-eminence of the psychic angle, of which the symptomatic manifestation by excellence is the compulsive use of psychoactive substances.

4.3.2. The objectives of the treatment of substitution

A majority of physicians declare that, for them, abstinence is not a primary goal. However, once again, the practices and underlying mental representations do not correspond to this principle. For others, less numerous, the psychosocial dimension of the problem is essential, and abstinence could be the final consequence of a psychosocial healing process. Some of them believe that, sometimes, the patient has *"to follow his path"*, and that the objective of the treatment is to guide him and try to limit his suffering. Other physicians consider that when the relation to the substance has been neutralised by the treatment, guiding the patient is more a question of dealing with the psychoactive dimensions. Although not often considered as an objective as such, abstinence still remains the ideal of the great majority of physicians who often repeat the same remarks: *there are a lot of relapses, but some people do actually succeed* [not to use methadone without relapse, thus to stay clean]", *"we try to reduce as much as we can, but sometimes it's not easy, some of them will never cope with it "...* A great majority of physicians say that abstinence was an objective at the beginning of their career, *"but we soon had to forget these illusions, most of the time abstinence is impossible"*. Then, a certain pessimistic pragmatism tends to replace the objective of abstinence by an objective of maintenance.

M*aintenance* represents a modality of the substitution treatment where, technically, the patient regularly receives a medication of substitution without setting a deadline to the treatment. This objective is mentioned by most of the physicians with a frustrated ideal of abstinence. Furthermore, physicians do not frequently use the term "maintenance". They more spontaneously speak in terms of "support", "chronic support" or "stabilisation". Most of the physicians consider drug addiction as a chronic disease. These physicians place themselves in a minimalist position: the pathology is described as chronic and calls for a treatment also considered as chronic, unless exceptional circumstances would lead to a hypothetical spontaneous healing. The debate that opens then concerns the place of the general practitioner towards psychological or social problems that are considered determining for the good functioning of substitution treatments. If the physician believes that there are reasons enough to intervene in these fields, can he intervene on the psychosocial level –*"every sickness reveals a psychological dimension, this is part of the global medical approach…However,*

many physicians are scared and restrict themselves to "ready-made" categories" – or is it the role of other actors, such a psychologists… *"but they don't like the psychologists and they are not asking for one"* ? At this stage, maintenance turns to acquire a new meaning: instead of being an approach by default, it constitutes a technique that open doors to a more psychotherapeutic treatment, an approach that aims at neutralising the place of the substance.

4.4. The treatment's process

4.4.1. Control and dosages

Basically, the medical consultations follow the same pattern in private offices as in institutions. However, some particularities deserve to be stressed out. A few physicians pay attention to the controls. Physicians whose conception of drug addiction focuses on the substances are more interested in these aspects. On the contrary, physicians who perceive drug addiction as a problem where psychosocial aspects are essential, have more ear for the feelings of the patients than for objective measurements of their drug consumption. The practices are equally diverse concerning the dosage. All physicians have a good control of this part of the treatment: they are correctly informed about the usual practised dosage, of its limits; they know the possible symptoms of a too light or a too heavy dosage. The further flow of the treatment is more subject to variations. Institutions have their own rules. In private offices, some physicians keep an absolute control of the dosage of the substitution treatment. In general, they aim at a reduction of the dosage. If the patient shows signs of weakness, the physician will decide to increase the dosage and wait for new positive signs. For these physicians, the treatment consists in different phases of reduction and re-augmentation of the dosage in function of the patient's contingencies. For other physicians the dosage is the outcome of a negotiation with the patient. Finally, a certain amount of physicians waits for the patient to take position in this matter. The patients are mostly in favour of a reduction of the dosage and the task of the physician is often to moderate these requests.

Apart from the basic symptomatic elements, all physicians make their clinical opinion based on direct information given by the patients about their own life. *"If they find a job again, it is mostly a good sign", "When it gets better with their family or their girl(boy) friend", "they admit when they are not going well, they don't need much, a small incident and there we go! They relapse", "The important thing for them is to regain stability in their life, their work etc.; then, even if they take methadone for the rest of their lives, it's not serious". "In the beginning they mostly talk about heroin and material problem... Afterwards they mostly talk about their families. Then, after a while, they talk about the future. Then I know they are going better because they stopped talking about the substance..."* Therefore, a particularity of the substitution treatments would be that the elements allowing the physician to ensure the follow up of the treatment are of psychological or socio-relational nature and not of bio-medical nature. Thus, most of the physicians believe that their patient is going better if the patient says so. Other physicians do rely on psychosocial "objective" elements, such as finding a job again or an improvement of the social and family relationships... Finally, some physicians base their opinion on a psychological evolution of the patient, such as his regained interests in things.

4.4.2.Clinical Good Sense and the specularity of the relations

If the physician has to rely on psychological and social elements to ensure the good follow up of the treatment, the question is then raised about his level of competence in these fields. The great majority of physicians consider not having been sufficiently trained in these

fields. We must notice the relative perplexity of the physicians when confronted to some situations: missed appointment, abrupt interruptions of the treatment, refusal to talk, coming too late at appointments, stories of stolen, lost of lent substances... *"In the end, I realised that it was when I thought they were going better that in fact they weren't"*. Some physicians have developed sensitivity to these particularities of the relational dynamics. However, these physicians have adopted this approach mostly for personal reasons and not for professional ones. About the other physicians, one is entitled to wonder about the limits of medical clinical good sense in the relational psychosocial fields. This constitutes a weak point in the therapeutic process of the patients in substitution treatments: it opens the door to a psychotherapeutic work. If this is not the competence of the physician, and if furthermore the patient is not followed by a psychotherapeutic actor, only chance or destiny can grant success of this opportunity.

4.4.3. The physicians and psychosocial actors

The social assistants are mostly recognised for their administrative organisation role and their help in regaining social supports (social security, disability, housing, allowances, unemployment indemnity…).

The role of the psychiatrist is recognised for patients with patent psychiatric co-morbidities. Actually, physicians assert that a large number of their drug addicted patients suffer from other psychiatric pathologies. A fourth model of drug addiction emerges : for some patients showing psychiatric co-morbidity, the substitution treatment is the way to have legal and medical access to opiates, and the treatment appears then to be a chronic support of the psychiatric pathology, and not of the addiction syndrome.

The relationship between physicians and psychologists or psychotherapists is more complex. There is a *continuum* of opinion, ranging from a relative ignorance of the psycho-relational dimension to a total personal involvement in the psychotherapeutic field. The most frequent situation is the one of a physician who is perfectly aware of the impact of this dimension but who does not clearly perceive the specificities of the psychotherapeutic approach or does not consider himself as entitled to work on such a request for treatment. The situation is clearly different in institutions where these roles do cohabit. However, the institutional organisational process has to allow each actor to play his own role and the communication between the actors about the patient has to be qualitatively and quantitatively sufficient. This is a recurrent problem in the institutions where the necessary time for this communication is often lacking.

4.4.4. Order and disorders, stabilisation and relations to the social norm

Thus, for a majority of physicians, the major criterion of evaluation of the substitution treatment is based on the stabilisation, namely the control by the physician of the quantity of opiates used by the patient, which is set and maintains itself along with the socio-relational stabilisation that is expressed by a better adaptation to the social norm, especially in terms of employment, family relations and more simply a "normal" social behaviour. Is it legitimate to assimilate well-being or health with stability and respect of the social norms ? This is the central question in the field of drug addiction and substitution treatments and it is the task of the physicians tot take position in this matter.

4.5. Drug addicts / Drug addiction

Generally, all physicians assert that they have not been sufficiently trained to face drug addiction problems. Therefore, many of them regret the fact that they started to deal with drug addicts with *"a lot of clichés in their head*". Most of them admit having made a lot of progress in their perception of the problem. The most common trend is the reduction of their demands: *"In the beginning one is rather strict and idealistic, we believe that with a little discipline and trust everything can be solved. But we learn not to want the good of the patient in his place "*. On the level of practical organisation of these treatments as recently established in the Royal Decree of the 19th march 2004, guiding and training physicians constitutes an important item. The physicians are rather reluctant to the idea of legislating in the field of training .It is up to the medical profession and not to the legislator to organise such a process. A majority of physicians insist on the idea that, thanks to the interest and specificity of the organisation of treatments for drug addicts in Belgium, patients can be completely treated by a general physician.

5. Conclusions and recommendations

Ten years after the Conference of Consensus in Gent, it is, above all, important to place the present situation in its context of evolution. **From this point of view, the balance sheet of the practices of the substitution treatments in Belgium is positive.**

In fact, the variety of treatments in this field is relatively high, with possibilities of a complete treatment of the problem by either the general physicians, either a wide range of institutional channels. Furthermore, this range of treatment is not only quantitatively but also qualitatively wide and diversified — to the extend that the standardised evaluation instruments in this field could not be correctly implemented in Belgium. Although the range of treatment is wide, it does meet a large variety of existing needs. It appears that in fact, as well the medical practice as the institutional practice correspond to different types of patients, or to different moments in the patient's path that would not find, at this particular time, a satisfactory solution to his problems in another channel. **Thus is seems essential that these two large modalities of treatment remain and continue to develop.**

It is also important to stress that the physician who took part in this research all have a high degree of responsibility in the management of the treatments and the practice: all the physicians we interviewed had acquired the necessary knowledge and the technical know-how in terms of substitution treatments by coming in contact with this specialised field or by reading specialised literature. They all are careful to avoid potential abuses from their patients; they all are organised to avoid ambiguous situations in their relationships with the patients; the physicians working in private offices have a relatively limited amount of patients and do not wish to treat more of them. It is thus relatively clear that some of the fears expressed before the Conference of Consensus about the fact that legalisation of the substitution treatments would lead to deviations or abuses did not come true. Furthermore, if it is typical to our country to stress the regional differences, our research seems to show that, in terms of substitution treatments, the great diversity of practices is not related to the regions or to the types of medical network (Private offices *versus* institutions).

Of course, these observations are inherent to our sample and one can imagine that, if dishonest and crooked physicians exist, they did not contact us to take part in this research. However, we did not hear a single time about such physicians, and this proves at the least that, if they exist they are only the exception. Thus, from a general point of view, and despite

the judicial emptiness until 2002, the substitution treatments in Belgium were satisfactorily implemented and this under the professional supervision.

The vision of the interviewed physicians has also evolved compared to the opinion expressed 10 years ago by the medical profession in general: a lot of clichés on drug addiction and drug addicts have disappeared –mainly the cliché about *"a natural tendency to dishonesty"* as a physician mentioned– and the objective of abstinence as a systematic preliminary objective to any therapeutic approach is not the prevailing opinion anymore.

Nevertheless, beyond this general context considered as globally satisfactory, some relative important difficulties must be stressed out, as for example the objectives of the substitution treatments through the diversity of practices. We have seen that if many physicians do no consider abstinence as an inevitable preliminary stage of the treatment, this objective has not been replaced by another positive objective of the treatment. As a result, we note a generalisation of maintenance mostly described as "stabilisation" or as "normalisation" and perceived as an objective by default. In fact, the study of the analysis shows a difference of approaches by the physicians towards new patients or patients already in treatment. For the "*new patients"* since less than 6 months of treatment, the objective of abstinence remains very persisting, and is constitutes a short-term goal. The physicians and the patients are placed in logic of progressive withdrawal, and the frame of the treatment is stricter. One could say that, for these patients, the therapeutic hope, understood as the possibility of a possible healing – understood as the suspension of all drug use– remains high.

But, the longer the treatment, the further away the ideal pattern. One evolves toward a treatment's scheme aiming at maintenance by default. Thus, for the "*long term patients"* – treated for more than 24 months– the frame of the treatment loses importance, abstinence is no longer an objective of the treatment and the problem to be treated could be described in terms of chronic pathology that are to be followed up in the hope of an hypothetical spontaneous healing — an improbable change in the life of the patient. Thus, in one way, the therapeutic hope of these patients, understood as the suspension of the drug use, clearly tends to fade away.

Finally, in one case or the other, the ideal objective of reaching abstinence keeps stand, even if it seems an impossible achievement. This is why maintenance is described as an objective by default. The fact that the great majority of the physicians admit that drug-addiction finds its roots in a somewhat more psychic and / or social problem that occurred in the life of the patient, and the fact that the manifestation of an addiction syndrome is more the expression of a deep feeling of bad being, has not contributed to change the comprehension of the problem to be treated, neither to an adaptation of the objectives to be attributed to the practices and the treatment required.

A determining explanation of this situation is probably to be looked for in the organisation of the physicians' training in the field of addiction and more generally concerning the psychological and/or social dimension of some pathologies of which drug addicted are obviously the best example. However, it matters to underline that if this training can seem insufficient in the field of the psychosocial problems at stake, a lack of clarity on this matters is also characterising the position taken by the representatives of the sector and specialised in the field of drug addiction.

1. Improvement of university trainings for physicians in the field of addiction

The Law of August 22nd 2002 and the Royal Decree of March 19th 2004 particularly insist on the training of physicians. In fact, any physician prescribing substitution treatments

has to be an agreed general physician or a specialist *"who has, during or after his medical degree, been specially trained to treat addicted patients and implement substitution treatments or who, by the time the law was enacted, have the necessary expertise in this field; by specific training,* [...]*, we mean a training organised by a scientific organisation of general physicians or specialists, by a centre of assistance for drug addicted, by a network of treatment of addicted patients or by a specialised centre. By expertise, we mean a specific training and permanent training, the knowledge of pharmacology, scientific literature and experience in substitution treatments* [...]. *Any physician administrating substitution treatments have to give the proof of his permanent training, the reading of scientific literature in this field, and his participation to the activities of a help-centre or a network of treatment for addicted or a specialised centre "*[1].

Our research brought into light that, physicians who presently practice substitution treatments undoubtedly meet all legal requirements. However, at the same time, it seems that in the field of substitution treatments practices, the physicians do not wish to be classified as "specialised" in drug addiction; they would rather limit the amount of these patients — this makes sense, also in terms of quality of the health care. It is thus highly probable that a young physician making today the choice of starting in a private office as a general practitioner will refuse to invest time in order to treat one, two or three addicted patients at the most. **In this case, the future offer of medical care for addicted patients by the general practitioner is likely to decrease**.

At the same time, it seems that the basic training for physicians in the field of drug-addiction in the course of their academic studies is clearly insufficient, even non-existent. **It seems essential that this frequent pathology in our modern societies has to be the subject of a greater attention in the university medical classes; so that any general physician would be able to practice substitution treatments without necessarily follow a complementary specialised training.**

2. Greater awareness of the physicians about the psychological and social dimensions of drug addiction.

The requirements in the field of physicians' training do not only concern drug-addiction problems, methods of medical treatment, symptomatology and/or pharmacology of substitution treatments. In our research, we have seen the importance of psychological and social problems of drug addiction and the difficulty these dimensions represent for the physicians. On the one hand, physicians seem to pay little attention to the detection of psychosocial requests of their patients. On the other hand, though they acknowledge this importance of drug addiction problems, they seem not to know very well the specificities of the work to be done in this field. This point is part of the much larger question of the approach of the psychosocial dimensions, pathology syndromes, or pathologies commonly encountered in the general practice of medicine (insomnia, depression, pain and other psychosomatic suffering…).

Thus, it appears that it would be **essential to dedicate a larger part of the basic academic training to these psychosocial dimensions.** The intention is not to turn every physician into psychotherapists but to grant **a basic training in medical psychology,** rather than to psychiatric pathologies (relationship physician-patient, relationship physician-family,

[1] SERVICE PUBLIC FEDERAL SANTE PUBLIQUE, SECURITE DE LA CHAINE ALIMENTAIRE ET ENVIRONNEMENT, *Op. Cit*., Art. 2§1, pp. 35 927-35 928

motivational approach, interviewing and listening capacities, psychology of pain, traumatism, stress…)

Furthermore, it is essential that the present structures of training within the medical profession (GLEM, Balint groups...) integrate some considerations about the relationships between the medical profession and the psychosocial dimension of some pathologies, and of course, in the field of drug addiction where these domains are of vital importance. The problem is to better define the role of the physician and of the medical profession regarding these problems, and to clarify the different relationships between the physicians and the other therapeutic actors in the field of substitution treatments.

It seems important to stress the fact that most of the physicians are reluctant to the idea of a specific legislation in the field of health care for drug addicts. If we admit that drug-addicts could be treated by general practitioners as well as any other pathology, it is not coherent to enact a specific legislation for them rather than rely on traditional medical channels (universities, scientific societies of general medicine, mental health platforms, provincial chambers and / or National Order of Physicians...). **It is important to invite them to express their ideas on the question so that they can contribute to the improvement of the quality of treatments in this field.**

Finally, so that general physicians would pay more attention to the psychological and social dimensions of some pathologies, **it would be desirable that the INAMI would recognise as a medical service the long interviews with patients** (as it is the case for psychiatrists).