April 26, 2013

ATOME (Access to Opioid Medication in Europe) Meeting in Budapest, Hungary

Katherine Irene Pettus, Phd, IHPC representative to IDPC.

The ATOME project (http://www.atome-project.eu/) is an EU funded consortium of ten academic institutions and public health organisations formed to address the crisis of access to opioids for pain relief and harm reduction in twelve target countries.[1] In each country, local health and policy experts team up with international consultants to review legislation and clinical practice relating to all aspects of regulatory control of medical opioids. The goal is to align countries with WHO human rights and evidence based clinical standards in order to relieve avoidable suffering and improve public health outcomes, and the product will be individual country reports with targeted recommendations for legislative and policy change. Workshops have been held in Latvia, Greece, Cyprus, Turkey, and most recently Hungary (see http://eapcnet.wordpress.com/?s=ATOME for meeting reports).

What makes the ATOME project so unusual is that it brings together medical and policy professionals from the national palliative care and harm reduction movements to learn about common issues pertaining to outdated or inappropriate government control of opioids and real time impacts on the vulnerable populations they serve. These collaborative meetings are often the first opportunity these providers have ever had to meet and interact with one another as professionals and to hear from global specialists that alternative, public health and evidence based policies are not only achievable, but required under international law. As an example, Dr. Saskia Jűnger, of Bonn University, described an innovative joint session format used during the ATOME legislation review workshop at Utrecht University[2], involving legal experts from the various ATOME countries who reviewed *one another's* opioid regulations (as

[1] The twelve target countries of the Atome project are: Bulgaria, Cyprus, Estonia, Greece, Hungary, Latvia, Lithuania, Poland, Serbia, Slovakia, Slovenia, Turkey

[2] http://eapcnet.wordpress.com/2013/02/27/opioid-legislation-in-european-countries-expiry-date-exceeded/

opposed to just their own) in order to gain perspective on their own situations. Commenting on provisions that were unnecessarily burdensome or measures calculated to improve access, providers and policy makers heard that what they had come to accept as normal, their neighbors sometimes thought was outrageously cumbersome or perhaps an improvement on their own rules.(!)

Professor Sheila Payne, Director of the International Observatory on End of Life Care at Lancaster University, opened the Budapest session by welcoming Hungarian providers who had come from all over the country and introducing the first speaker, Dr. Willem Scholten, PharmD, MPA former team leader Access to Controlled Medicines at the WHO. Dr. Scholten reviewed the history of the ATOME project, which was initiated because of the problem with access to opioids for analgesia and treatment of heroin dependence in the twelve target countries. He was followed by Dr. Hanna Páva, Deputy Secretary of State for Hungary, who discussed the fact that until recently, when the INCB began urging countries to improve access to controlled substances, Hungarian opioid policy had focused on control rather than education or access. The recently updated WHO guidelines (http://www.atome-project.eu/documents/gls_ens_balance_eng.pdf) prompted the government to take legislative action by reducing excessive bureaucracy and red tape. Dr. Páva emphasized that health professionals' and medical providers' attitudes toward opioids play a key role in promoting policy change and improved access since many clinicians still associate opioid therapy with end stage terminal illness rather than best practice pain control. Because addiction medicine, pain control, and palliative care are not required courses in medical school curricula, medical "experts" generally suffer from "opiodophobia" and lack the requisite knowledge about dosage and appropriate use, a theme common to almost every speaker's presentation.

Hungary, where per capita opioid use is low relative to need, is a textbook case of the disconnect between legislation – the 1997 Healthcare Act expressly provides for the right to pain relief – and best practice pain and addiction medicine. This is where civil society and so-called physician "champions" of hospice and palliative care can intervene to promote change. Thanks to one such champion, Dr. Ágnes Csikos, who spoke in the afternoon, Pécs University Medical School now offers a degree in hospice and

palliative care, and courses in pain management that include basic communication are now a graduation requirement for all medical and nursing students. National prescribing regulations changed in January, eliminating the requirement that opioid prescriptions be produced in duplicate.

Dr. Tom Lynch of the International Observatory on EOL care introduced the global mapping project, revealing the disparities in palliative care provision around the world, from none at all in some countries, largely in the global South, to the "gold standard," in the US, the UK, Western Europe, Australia and New Zealand, where palliative care is considered to be "fully integrated." After the break, Dr. Scholten went into these inequalities in greater detail, presenting WHO figures on global opioid consumption: 93.8% of all (licit) morphine produced in the world is consumed by 21% of the global population. A staggering 4.5 billion people live in countries where medical opioid consumption for pain relief (terminal cancer, post-operative, chronic, etc.) and OST is near to zero. This translates, annually, into 8-40 million post-surgery pain patients, 5.4 million cancer patients, 1 million HIV/AIDS patients, and 0.8 million lethal injury patients whose pain is untreated.[3] (www.unodc.org/unodc/en/commissions/CND/session/55.html) In terms of per capita consumption, Hungary (at 76.31mg) is well below Germany (at 389.98mg) and Switzerland (at 282.10mg).

Péter Sárosi, who heads the Drug Policy Program at the Hungarian Civil Liberties Union, drew the audience's attention to the fact that there are multiple clinical and policy definitions of "harm reduction". From its grassroots inception as a local needle exchange program in a lavatory in Western Europe, harm reduction has become a global movement whose advocates seek to reach the approximately 16 million injection drug users worldwide, most of whom live in lower and middle income countries. The fact that opioid substitution treatment (OST) and needle and syringe exchange (NSE) are now widespread is a testament to the growing credibility of the injection drug users (IDUs) human rights movement. Just as

[3] Commission on Narcotic Drugs Fifty-fifth session (2012) *Promoting adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion and abuse* **Report of the Executive Director**, P.4

global access to palliative care varies wildly according to region and GNP, OST coverage also varies throughout the world, with 61% of users receiving treatment in Western Europe compared to one percent (1%) in Asia.

Although OST coverage is low compared to the EU average, the country has come a long way since the 1990's, when physicians who used OST risked prosecution. The Hungarian Civil Liberties Union represented a number of accused physicians, and by the early 21st century the situation had stabilized. There are now twenty NSE programs in Hungary, up from five in 2003. Law enforcement support is key to continuity and infection containment since Hungarian prison inmates, unlike their counterparts in Western Europe, have no access to OST. Overdose prevention is also lacking, as naloxone can be administered only by a qualified nurse or physician, so is available only in hospitals and ambulances. New challenges for harm reduction activists and healthcare providers are the cheaper "designer drugs" and psychoactive substances that have replaced heroin and opioids as the injection drugs of choice. The relatively unknown pharmacologies of these new drugs create entirely different, and often unknown, clinical risks that impact both users and health services. Moreover, because they are injected up to fifteen times daily (compared to ten for heroin) users without clean needles face higher risks of infection. Although HIV prevalence in Hungary is quite low, with foreigners accounting for the majority of cases, increased use of new injection drugs combined with the lower resources for NSE programs due to the economic situation, bodes ill for individual and public health. The litmus test is Hepatitis C prevalence, with 30% of IDUs in Hungary, and in some districts up to 80%, now testing positive. Reduced funding for harm reduction programs means that infection risks for vulnerable populations increase daily, and could well reach the crisis proportions now extant in Romania, where more than 50% of all drug users are HIV positive. (http://www.ipsnews.net/2012/11/new-hiv-epidemic-looms-over-romania)

Other program presenters included Dr. András Telekes, an oncologist who addressed the lack of medical school education on the subject of pain and addiction medicine. Vets and dentists are taught significantly more about pain than physicians and cancer specialists. Another oncologist, Dr. Judit Kismarton,

proposed mandatory courses for medical students in pain relief and advocated for lifting onerous opioid prescribing, dispensing, and reimbursement restrictions that harm patients. Dr. Jósef Csorba, an addiction and OST specialist, gave an overview of challenges facing the Hungarian harm reduction movement, particularly with the advent of the new street drugs. He advocated a proactive approach of hitting the streets to find the addicts who want help rather than waiting for them to come to the hospital in an ambulance. Pointing out that many opioid dependent people are unable to achieve abstinence because their brains can no longer generate endorphins, he recommended substituting legal for illegal substance use and allowing people to "live normal lives" rather than being branded as criminals. Oncologists who spoke of the need to revise the national regulations and educate providers in use of opioids were Drs. Judit Kismarton and Ágnes Csikos.

Four breakout groups met in the afternoon – sessions in Hungarian without translation (!) that discussed the list of essential medicines, access, and social support; provider training, protocols, and attitude; problems facing harm reduction practitioners and, finally barriers to the wide availability of palliative care in Hungary. Participants reported back to the plenary with many strong recommendations for mandatory physician and provider education in pain and addiction medicine, meaningful changes in prescribing and dispensing regulations, and increased financing for harm reduction programs and palliative care physician reimbursement. The latter is critical, particularly for outpatient and home visits – only one home visit per terminal patient is currently reimbursed – a change that would allow the dying to spend their last days supported at home (the stated preference of the majority of patients and families) rather than in the hospital.

A full report detailing the recommendations will be available later this year on the ATOME website. All in all it was an extraordinarily productive work day that brought together passionate and highly qualified individuals in an open-ended and informative dialogue focused on relieving suffering and improving the quality of life for individuals and communities throughout Hungary.