Hospital staff need more education on substance misuse and its complications. A hospital based drug and alcohol counsellor assigned to work specifically with older people may help identify misusers, while regular medical audit of substance use could also improve detection and referral rates.

Treatment should be based on a careful assessment and matching of each patient's needs to the range of treatment options available. Detoxification from alcohol may be indicated for some patients; others may need weaning off benzodiazepines, which may take weeks or months to achieve. Emphasis should be placed on non-drinking social activities in the context of the person's circumstances and social support networks. Individual counselling may be helpful for some elderly misusers, with a supportive and less confrontational approach to treatment, or referral to Alcoholics Anonymous. Disulfiram should be used cautiously, under supervision, and only short term since there is a risk of precipitating a confusional state.

Treatment specifically designed for elderly people may be more beneficial than programmes for mixed ages: older people frequently have concomitant medical and psychiatric illnesses and place heavier demands on health services. The most effective treatment may be that given through facilities that specifically serve elderly people.

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Policy on drug misuse in Europe

New monitoring centre should provide opportunity for more soundly based policy

Policies for managing drug misuse among the countries of Europe are characterised by unprincipled variations[1] and a dearth of information or analysis that would support systematic decision making. For the past two decades purely political priorities have been the dominant influences in many European nations. The establishment in the European Union of a Monitoring Centre for Drugs and Drug Addiction provides an important opportunity to change this climate so that future management of drug misuse is properly informed by science.

The current lack of information and analysis shows itself in several ways. Radical and interesting changes in policy, such as the removal of criminal sanctions for personal possession of psychoactive drugs in Italy and Spain, have gone unevaluated.[2] Few European nations conduct national surveys that would provide the basis for systematic estimates of the prevalence of drug misuse. In the case of France and Italy it has not been possible to identify survey data on drug misuse even at the city or regional level.[2] Moreover, in most countries the data that have been collected have remained almost unanalysed beyond official descriptive reports, themselves often buried in obscure publications. Rarely if ever have files been made available for secondary analysis by other scholars. In some nations estimates of the numbers of people dependent on illicit drugs have the precision of medieval estimates of the angel carrying capacity of pinheads. For Britain figures as diverse as 25 000 and 250 000 opiate addicts have been cited, and for Italy figures of 100 000 and 300 000 heroin addicts are equally plausible and equally unfounded.

Unsurprisingly, treatment also varies enormously, with scarcely any reference to a base of research and analysis. In Britain, the United States, and the Netherlands methadone is accepted as the centrepiece of treatment for opiate addicts on the basis of a substantial number of reports of reasonable (though not excellent) quality on the effectiveness of such treatment.[3] In some other European nations it is scarcely available at all.[4] Greece bans most opiate substitute treatment. France has a total of 52 patients receiving methadone, and Germany had fewer than 1000 patients taking methadone before 1992. In Spain and Britain the availability of substitute treatment varies greatly among regions, and in Italy methadone is mostly limited to short term prescription.[4]

The continued concern about the prevalence of HIV infection among intravenous drug users is leading to sharp changes in practice, which are not necessarily based on research or evaluation. Thus Germany has developed treatment facilities for 8000 people in the past two years, while French policy makers (after a decade of denial[5]) and health professionals are finally pushing for a major expansion in the availability of opiate substitute treatment. Pockets of opposing views remain—for example, in Norway and Sweden—but overall there seems to be a swing in favour of prescribing substitutes. On the basis of the available scientific evidence, the United Kingdom Advisory Council on the Misuse of Drugs has recently strongly endorsed the role of structured maintenance treatment with oral methadone in preventing HIV infection.[6] Unfortunately, earlier experiences suggest that rapid reactive shifts in attitude may be short lived and not soundly based. The recent Italian laws restricting the consumption of methadone to the confines of treatment centres are an example of reactive decision making inappropriately responding to the problem of methadone diversion.

Different models of mental illness and addiction across Europe also contribute to these sharply divergent responses,[7] as do differing systems of health and welfare provision. But the longstanding rejection of methadone in so many countries is symptomatic of the moralism that has characterised drug policy for so long and that makes analysis and research such marginal activities.

The establishment of the European Monitoring Centre for Drugs and Drug Addiction in Portugal during 1994 not only represents a step toward addressing the information and policy gap; it may also provide a battleground for airing

national differences. The centre aims to collate, analyse, and disseminate data on drug problems from member states and to facilitate the exchange of information and documents among member states. The centre comes in an era following the Maastricht treaty in which the European Commission seems keen to promote the public health dimension of drug policy. Drug misuse was also one of the subjects singled out for community action by the Health Council in December 1993. Moreover, the Maastricht treaty also commits member states to cooperate over justice and home affairs, including measures to combat the plague of drug misuse. At a recent conference Mr Fortescue, the director responsible for cooperation in justice and home affairs, suggested that such measures might include cooperation among doctors to harmonise the use of certain drugs and to analyse the medical evolution of the treatment of drug addicts.

After decades of fragmentation drug policy in Europe may now be converging, largely as a result of the relation between drugs and HIV infection. The establishment of the European Monitoring Centre for Drugs and Drug Addiction provides at last a facility to promote systematic collection and analysis of data to complement the useful recent work of the Pompidou group.[8]

Given the dearth of information, the task of the centre remains daunting. Nevertheless, the centre may yet provide the opportunity to put European drug policy on a sound basis, which would allow policy makers and professionals to challenge much of the presently entrenched moralism.

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Recent initiatives by the European Union

A new opportunity for promoting health

Widespread scepticism surrounded last year's signing of the Maastricht treaty. So far, the response to the treaty has been defensive—for example, to use the principle of subsidiarity to avoid previous responsibilities, notably in environmental protection (step forward, Britain). Sometimes the European Union itself contributes to this scepticism, as in its continuing subsidies for production of tobacco and its damaging proposal for a directive on data protection.[1]

The European Union needs to improve its image. Paying more attention to health could be one way of achieving this. Article 129 of the treaty gave the union competence in health protection and is concerned with preventing "major health scourges, including drug dependence."[2]

Last June, the council of health ministers stated that health policy should aim at "adding life to years, as well as years to life."[3] Proposals included improving the quality, comparability, analysis, and distribution of health data and developing ways to ensure that the effects on health of decisions taken on other topics (for example, research and the environment) are considered.[4,5] The council also called for continuity, coherence, and cooperation in health policy, implying the need for a strategic plan.

The responsibility of the new competence now lies with a division of Directorate General V of the commission, which is concerned with employment, industrial relations, and social affairs. This directorate already has a substantial track record in occupational health and safety and the European programmes against cancer and AIDS. Eight new programmes will be introduced over the next three years. They are health promotion, education, and training; the collection of health data and indicators and the monitoring and surveillance of diseases; cancer; drugs; AIDS and other communicable disease; accidents and injuries; diseases related to pollution; and rare diseases.[6]

Thus there is a combination of disease specific ("vertical") programmes and "horizontal" programmes concerned with coordination and infrastructure. The horizontal programmes include further development of health education activity in schools, dissemination of the most effective practices, and the establishment of information networks for evaluating treatments and technologies. The programme to monitor health is not spelt out in any detail; hopefully, it will include risk factors as well as diseases and will link with the work of the World Health Organisation rather than duplicate it.

Some of these points are emphasised in a resolution of the European parliament, which followed a public hearing last June.[7] The parliament strongly supported establishing a European Epidemiological Investigation Unit within Directorate General V to analyse high quality data from member states and to feed the results into policy. It also wanted a report on the state of health in the union.

In addition, parliament called on the commission to develop a programme on health promotion and education and on disease prevention, to set up a transfrontier network for collecting reports of notifiable diseases, and to encourage greater use of generic drugs. Cardiovascular diseases and the problems of elderly people were added to the priorities identified by the directorate. Exchange of information between national health systems was encouraged, as was the setting up of exchange schemes for health care professionals. Finally, the parliament called for the appointment of a commissioner specifically responsible for coordinating all aspects of public health policy, including research.

Last December the council of ministers decided to continue the existing programmes against cancer and AIDS, with some suggested improvements. It reaffirmed the need to achieve