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EUROPAD formerly EUMA was founded in Geneva (Switzerland) on September 26, 1994. It shall remain independent of political parties and of any government. The object of EUROPAD is to promote, in the EU and elsewhere, the effective treatment of drug addiction, especially heroin addiction, in particular, but without prejudice to the generality of the foregoing:

1. to promote the development and acceptance of treatment with methadone and other prescribed medicaments (buprenorphine, LAAM, heroin, naltrexone) including long-term prescribing;
2. to enhance the provision and quality of services to drug abusers and their families, especially heroin addicts;
3. to promote a better understanding of methadone treatment by the general public and its elected representatives and officials;
4. to promote collaborative research and to provide a European research centre;
5. to work with the American Methadone Treatment Association to promote support for methadone treatment worldwide;
6. to promote good will and cooperation among the staff of methadone and other medical treatment services in Europe and elsewhere,

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Managing benzodiazepine withdrawal

Franco Frare and Giulio Perugi

Summary
The long-term use of Benzodiazepines (BZs) is currently a source of growing concern, owing to increasing doubts about their efficacy, and evidence of important adverse effects, including physical dependence and neuropsychological impairment. The long-term use of BZs in patients with anxiety and mood disorders calls for special concern; in these patients, in fact, interepisodic chronicity and residual symptoms often appear to be related to inappropriate long-term use of BZs. The problem of dependence on benzodiazepines has been aggravated by iatrogenic physiological dependence on these medications and by polysubstance-abusing patients using them in addition to other agents, in particular opioids or cocaine. A safe, rapid, and effective way to detoxify patients from benzodiazepines is of prime importance in facilitating further treatment of their psychiatric or substance use disorder. Correct withdrawal strategies should combine gradual dosage reduction, psychological support and adjuvant medications in selected patients. The tapering schedule should be individually titrated and adjusted according to the patient’s reactions; substitution with a long-acting BZ is often useful. Psychological support should include information about BZ withdrawal, general encouragement and the correction of misconceptions about discontinuing medicines; it should be available both during tapering and after withdrawal. Some antiepileptics and sedative antidepressants may be useful to mitigate withdrawal phenomena. Adequate dosages of antidepressants should be used to treat the re-emergence of an underlying mood or anxiety disorder. Success rates of withdrawal are high (54-92%); the follow-up studies, however, indicate that long-term discontinuation of BZ is a slow process, taking many weeks or months - in some cases years - with a protracted clinical course after drug cessation.

Key words: Management of Benzodiazepine withdrawal - Drug tapering - Anxiety - Mood Disorders - Opioid dependent patients - Polydrug abusers

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Introduction

Introduced over three decades ago, benzodiazepines (BZs) were thought for many years to be an effective and relatively safe long-term treatment for anxiety and insomnia. General practitioners quickly recognized these drugs as the treatment of choice for anxiety states, insomnia, tension and many psychosomatic complaints, while psychiatrists used them widely either for specific anxiety disorders such as panic and generalized anxiety disorders, or as symptomatic treatment for anxiety and insomnia in patients with mood disorders. During the last 15 years, however, doubts about the appropriateness and overall benefits of long-term treatment with BZs have risen steadily, as knowledge about dependence liability, withdrawal phenomena and side effects have surfaced [2;34]. Considering the doubts now being expressed about their long-term efficacy, the risk of adverse effects such as neuropsychological impairments [67;68], and the evidence of physical dependence, the advise currently given is to gradually withdraw patients with long-term use from BZs.

It is now recognized that chronic BZ use can induce physical dependence in 40-100% of subjects [49;53;63]; a well-defined withdrawal syndrome has been identified, the commonest symptoms being anxiety, restlessness, insomnia, agitation, irritability, muscle tension and tremor [2;12;34;53;63]. Other, less common ones include nausea, lethargy, increased perceptual sensibility, metallic taste, aches, pains, blurred vision, depressed mood, nightmares, hyperreflexia and ataxia [2;34,35]. Severe clinical features such as psychosis, seizures and confusion are uncommon but occur in polydrug abusers, alcoholic patients and elderly people [2;34;44;48].

There now appears to be a consensus that most patients will develop iatrogenic physiological dependence on BZs with chronic use, even at moderate therapeutic doses. It is important, however, to differentiate physiological dependence from substance abuse or addiction. BZ use becomes abuse and/or addiction when the patient shows loss of control, use despite adverse consequences, and compulsion to use. Patients may escalate the dose and/or engage in dysfunctional behaviour associated with procuring the medication. It has been shown that abuse becomes more probable when the patient has a previous history of substance abuse problems. Such patients tend to use BZs in combination with other drugs either to augment the euphoriant effects, or to counteract the negative effects of the primary drug. Both patients with a primary indication for BZs who are, iatrogenically, physiologically dependent, and polysubstance abusers with both physiological dependence and abuse/addiction, may need to be withdrawn from BZs.

Management of Benzodiazepine withdrawal

Preliminary evaluation and treatment settings

Physical examination, with a detailed psychiatric history (especially as regards comorbid mood, anxiety and substance-abuse disorders), and an accurate evaluation of the social and interpersonal context, should be the preliminary steps. The results of any previous discontinuation attempt should be investigated, with special reference to
sustained relapses of the original disorder and the intensity, phenomenology and course of the withdrawal syndrome. Subsequently, the treatment setting must be established.

Patients are often able to stop BZ on the basis of gradual tapering and the availability of simple advice, so that they can be treated by general practitioners. These patients generally include subjects with no definite psychiatric disorder and those who have initiated long-term use for simple insomnia or minor somatic complaints. Patients must be cooperative, must refrain from the abuse of alcohol and other substances, and must be capable of keeping to a tapering schedule.

Other patients, however, do usually require more careful monitoring, and may need a structured psychological treatment or adjuvant medications; these subjects can best be treated in a psychiatric setting. Patients with anxiety or mood disorders, such as panic disorder, major depression or bipolar disorder, and polydrug abusers, as well as subjects with a craving for sedatives, generally belong to this group. A history of unsuccessful BZ withdrawal or the repeated inability to follow dose regimens may also make referral to a specialist advisable.

BZ discontinuation in patients who were taking supratherapeutic doses or had a history of mood, anxiety or substance abuse disorders usually requires treatment in a specialist setting, with greater involvement on the part of the physician. Drug tapering must be more gradual and carefully tailored to the individual; it should take into account current symptoms, personal history and concomitant psychopathology. Psychological support is fundamental in order to ensure successful BZ discontinuation in these patients. Moreover, adjuvant medications or structured psychological therapy may often help to control withdrawal symptoms and treat comorbid mental disorders.

The underlying psychopathology, patient reliability and compliance, and the presence of family support should all be considered in the choice of treatment setting. If the patient is to be treated as an outpatient, a strong support system is required. Relatives should be adequately informed and involved in the planning of treatment. The medical staff should provide continuous assistance and a doctor should be always available by telephone.

Hospitalization is generally required if there are severe medical or psychiatric comorbidities, or dangerous withdrawal complications occur, such as severe panic states, depression with suicidal ideation, mixed states, acute or psychotic states, delirium or convulsions. Polysubstance dependence or the unreliability of the patient may also suggest hospitalization, especially if the subject has poor social support.

Drug tapering

As a general rule, the tapering of dosage should be gradual in all long-term BZ users. Anyone who has taken a benzodiazepine for two weeks or longer should be tapered from the drug. Patients who were taking therapeutic doses of BZs and have no history of mood, anxiety or substance abuse disorders typically tolerate a fixed dosage reduction fairly well.

A tapering schedule agreed upon by several authors involves an initial reduction of 10 to 25 per cent (a greater initial reduction is generally better tolerated for high-range therapeutic doses). Subsequent reductions of 10 to 25 per cent once a week may be
implemented. If clinically significant withdrawal symptoms emerge, reductions should proceed more slowly, and, if necessary, the dosage may be stabilized for a few weeks until symptoms subside. In general, the tapering schedule has to be adapted to the patient according to clinical observations after each dosage change. In the last phases of tapering it is usually best to ensure a more gradual discontinuation by halving reduction amounts or scheduling them every other week.

Most patients of this kind will be able to stop BZ consumption with little effort, by utilizing gradual tapering. It may be useful to teach sleep-hygiene measures in order to cope with the re-emergence of insomnia.

In patients who have a history of mood or anxiety disorders, or who are taking supratherapeutic doses, drug tapering usually requires a more flexible schedule, with particularly careful supervision by the physician.

Gradual tapering is of the utmost importance in attenuating drug factors which contribute to the severity of withdrawal, such as BZ half-life and potency, daily dose, and duration of use [53;63]. Severe panic states, acute confusional or psychotic states, or convulsions can occasionally occur following abrupt BZ withdrawal, especially from high doses. When a short half-life BZ has been utilized, it is best to switch the patient to a substance with a long half-life, such as diazepam or clonazepam; the more gradual reduction in blood levels should ensure a greater overall tolerability of the withdrawal syndrome, as shown by the lower dropout rate during gradual long-half-life vs. short-half-life BZ tapering [63]. Besides this, the fluctuation in blood levels between doses is less marked, and a single daily dose toward the end of the taper may give good 24-hour coverage. Moreover, in our experience it is also preferable to choose the oral solution form, taken 2-3 times a day, if it is available, as this form of administration allows a more accurate splitting of the dosage and, therefore, a more gradual discontinuation.

In setting up the tapering schedule, factors to be taken into account comprise baseline dose, duration of use, environmental stressors, the patient’s physical health, personality and concomitant psychopathology. The presence of panic disorder, in particular, requires a more gradual schedule, as these patients are prone to the catastrophic interpretation of withdrawal symptoms. The starting dose, along with concomitant psychopathology, largely determines the size of each dosage reduction. In the initial phases, patients who use high doses can generally withstand greater dosage reductions than those on lower doses.

A typical dosage schedule may involve decrements of 0.5-2 mg diazepam (or equivalent) every 3-7 days (once or twice a week). Initial dosage reduction of 2 mg at a time may be more appropriate if patients are taking more than 20 mg/day of diazepam (or equivalent). When dosage has declined to 4-5 mg/day, decrements of 0.5 mg may be better tolerated. If the patient experiences withdrawal phenomena that are too intense, or major environmental stresses arise, the reduction amount or frequency should be lessened until symptoms subside; the rate of reduction can be slowed to 1 mg every other week, and some patients only seem to tolerate reductions of no more than 1 mg per month. Generally, the patient adapts better to withdrawal symptoms if he or she feels that
he can determine the withdrawal rate. This is particularly important in the case of patients with panic disorder (PD) or generalized anxiety disorder (GAD), as it will help to minimize the catastrophic interpretation of withdrawal symptoms. When craving for sedatives is present, a physician-controlled withdrawal schedule may be more appropriate, especially in patients with polydrug abuse.

The amounts and frequency of reductions are best provided in a written schedule, with dosages and weeks clearly marked. In order to keep a schedule that has been agreed on, the physician may consider an occasional as-necessary dose. Patients should be reviewed at least weekly and should be encouraged to call the doctor over any concern (whenever they feel unable to control their symptoms or to comply with the schedule). As a rule, the rate of discontinuation should be higher in the initial stages of tapering than in the final ones, as most withdrawal symptoms occur in the second half of tapering [53;63]. A further extension of tapering by means of very small doses every other day is sometimes useful in minimizing psychological dependence.

Detoxification from supratherapeutic doses of BZs generally requires a similar approach. Many clinicians prefer to hospitalize such patients, owing to the greater medical risks associated with supratherapeutic dose withdrawal. Hospitalization is generally required in patients with medical or psychiatric comorbidities, poor social support, and polysubstance dependence, or if the patient is unreliable. Patients may be tapered using the benzodiazepine that they have been taking or, preferably, be switched to a drug with a long elimination half-life. The estimated equivalent dose is administered in divided doses on day 1, to be certain that an accurate history and an appropriate equivalence are established. If the physician is unable to determine the exact supratherapeutic dose the patient has been taking, 20 mg of diazepam may be given every two hours until mild sedation occurs. The total dose required to induce mild sedation is then considered to be the initial dose. Patients are then stabilized on that dose for two to three days, followed by 5 to 10 per cent daily reductions.

The length of time needed for the drug discontinuation procedure is not predictable, and may range from a few weeks to several months. If the patient is frequently unable to comply with the schedule or repeatedly self-administers extra doses, a day-hospital regimen should be considered; hospitalization may be appropriate if severe complications appear during withdrawal, such as worsening of panic, depression with suicidal ideation, mixed states and delirium.

**Psychotherapy**

Psychological support is a very important part of the withdrawal plan, and effective anxiety management can be crucial to success in withdrawal and the prevention of relapses. The degree of support required varies individually: in many cases simple encouragement and information from general practitioners will suffice. Some reports indicate that even minimal interventions (brief advice and a self-help booklet, a letter, a short interview) delivered by a general practitioner may help chronic users to reduce their intake of BZs [8;15].
Some subjects, such as patients with anxiety or mood disorders or those who were taking supratherapeutic doses of BZs, usually require more extensive support; in most cases, regular psychological intervention may be administered during weekly visits to monitor drug tapering. Patients should be encouraged, and given information about the characteristics of withdrawal-related symptoms, while any misconceptions about the effects of discontinuing medicine should be corrected. It is helpful to supply clear information about the physical and mental mechanisms of withdrawal, anxiety and panic; it should also be explained that slow and individually titrated dosage reduction rarely causes intolerable distress. Some patients are prone to misinterpret withdrawal phenomena as signs of physical or mental illness; it is important to emphasize that symptoms are temporary, are not a sign of disease, and that the patient will steadily gain control over them. The use of a diary to record mood states and their precipitants may help to foster a sense of control over withdrawal symptoms. Instruction in anxiety management skills, relaxation techniques and breathing exercises may prove useful in some cases.

A minority of patients may require a more structured intervention, such as a formal cognitive or behavioural therapy. Several studies suggest that cognitive-behavioural therapy may be effective in fostering the successful discontinuation of BZ use. One study [58] reports that a group of 42 long-term users of therapeutic doses of BZs received cognitive-behavioural treatment. Patients were randomly assigned to either gradual tapering or abrupt cessation (with placebo substitution) of drug intake and received on average five weekly therapy sessions involving goal setting, daily self-monitoring, identification of anxiety-provoking situations, and development of cognitive and behavioural coping. At the end of treatment, 18 subjects had discontinued BZs (43%), with no significant difference between drug and placebo groups (30% for drug and 58% for placebo). At a 1-year follow-up those treated with placebo were significantly more successful in maintaining abstinence. Reports from other studies [17;28;45] are concordant in suggesting that cognitive-behavioural treatments based on anxiety-management and cognitive-restructuring techniques may help long-term BZ users to successfully taper the drug. As patients with panic disorder experience greater difficulties in discontinuing BZs [18;43], a group of 33 long-term BZ users with PD was randomly assigned in a recent study [46] either to slow taper alone or to taper plus 10 weeks of group cognitive-behavioural treatment. Therapy was based on the correction of catastrophic interpretations of symptoms, structured exposure to somatic sensations of anxiety, teaching and practice of cognitive and somatic coping skills. The rate of successful BZ discontinuation was significantly higher in the group receiving taper plus cognitive-behavioural treatment (13 of 17: 76%) than for patients assigned to slow taper alone (4 of 16: 25%). At the 3-month follow-up evaluation, 77% of the patients in the cognitive-behavioural programme who had successfully discontinued the drug remained benzodiazepine-free. A similar study compared slow taper of alprazolam with supportive medical management and the same taper procedure with 12 weeks of individual cognitive-behavioural treatment. The taper rate was slower than in the previous study.
All 12 patients who underwent cognitive behavioural treatment were able to discontinue BZ, compared with 8 out of 10 with medical management (the remaining two patients were switched to the CBT group). At the 3-month follow-up evaluation, 92% of patients in the CBT group and 40% in the other group were still BZ-free [65]. A subsequent 5-year follow up revealed that 9 out of 12 (75%) patients that had received CBT had been able to maintain CBT abstinence [10]. Cognitive-behavioural therapy may therefore be indicated for subjects with a history of previous unsuccessful discontinuation attempts, or of comorbid anxiety or phobic disorders. It may be particularly useful when adjuvant medications are controindicated or are refused by the patient.

Adjuvant Drugs

Adjuvant drugs are indicated whenever adjustments of tapering schedule and psychological support fail to control withdrawal symptoms or there is a re-emergence of previous mental disorders. They may also be useful when structured psychological treatment is not available or the patient refuses it.

Several drugs have been proposed in order to mitigate the BZ withdrawal syndrome. Controlled studies have shown the generally low level of efficacy of beta blockers [1;13;71], alfa2 agonists [24;31] and progesterone [60]. Propanolol has been shown to be minimally effective in reducing some physical symptoms of BZ withdrawal syndrome, such as palpitations, tremor and muscle twitches. However, this beta-blocker has little or no effect on subjective distress and do not reduce the overall incidence of withdrawal symptoms or dropout rates [25;71]. As regards buspirone, the results are mixed, but controlled studies indicate an overall inefficacy [5;37;61]. A more recent controlled study has reported a significant effect of buspirone compared with placebo in facilitating BZ discontinuation, but the patients had been using Bzs for a period much shorter (< 3 months) than in all other studies [14].

Antiepileptics have been utilized, especially in the management of withdrawal from high dosages of BZs or in patients with Bipolar Disorder. Some reports have indicated the usefulness of carbamazepine [19;33;55;62;66] administered in doses ranging from 200 to 600 mg/day. In particular, in a controlled study of 40 patients with long-term daily BZ therapy, it was observed that, five weeks after drug tapering, significantly more patients who had received carbamazepine (dose range 200-800 mg/day) remained drug-free, despite the fact that no statistically significant differences in withdrawal severity could be demonstrated [62]. This was particularly true of patients taking more than 20 mg/day of diazepam equivalent, so the authors suggested that carbamazepine may be especially useful to patients withdrawing from high-dose BZs. Another study, which compared the effects of gradual BZ tapering alone vs. short-term carbamazepine treatment after discontinuation, found that withdrawal symptoms were significantly less severe during part of the observation period in the second group [19]. A double-blind, controlled discontinuation study comparing PD vs. GAD patients found that carbamazepine may have a selective efficacy in improving the outcome of BZ discontinuation in patients with panic disorder [32]. There has also been a report of two
cases of successful high-dose BZ withdrawal in two opiate users using carbamazepine (600-900 mg/day) \[42\]. The available reports therefore indicate a therapeutic effect of low carbamazepine dosages (200-800 mg/day) in mitigating the severity of BZ withdrawal. In patients with mood disorder, treatment with mood stabilizers has the additional benefit of helping to prevent the onset of depressive or mixed states. As regards the other antiepileptics, there are indications that valproate may be effective in the management of BZ withdrawal, especially in patients with panic disorder. A small case series \[4\] and some case reports \[39;56\] suggest that the efficacy of valproate in low dosages (200-400 mg/day) is comparable with that of carbamazepine, but it appears to have fewer side effects. More recently, a double-blind study \[54\] has compared the efficacy of valproate and trazodone vs. placebo in attenuating withdrawal and facilitating discontinuation in patients with long-term BZ use. Both valproate and trazodone allowed a statistically significant higher percentage of patients to remain benzodiazepine-free five weeks after drug tapering. Neither drug had any significant effect on withdrawal severity.

Antidepressant drugs may also be useful adjuncts in the treatment of benzodiazepine withdrawal. Antidepressants are clearly indicated in treating a pre-existing depressive or panic disorder, and clinical experience suggests that they are the best instrument in managing the emergence of depressive or severe anxiety symptoms during withdrawal. Both tricyclic antidepressants (TCA) and selective serotonin reuptake inhibitors are effective antianxiety drugs and may control an underlying anxiety or depressive disorder. Patients whose original symptoms are likely to re-emerge should take antidepressants in a dose effective for the underlying psychopathology for at least 3 weeks before BZ withdrawal is initiated. Moreover, in our experience, low doses (25-100 mg/day) of sedative TCA antidepressants such as amitriptyline or trimipramine have immediate effects, and can be a useful tool in promoting sleep and lowering anxiety levels. One study has shown a significant effect of imipramine (25-225 mg/day) in relieving withdrawal symptoms in patients with panic disorder and generalized anxiety disorder \[50\]. According to more recent data by the same research group, imipramine in comparison with placebo significantly improves the taper success rate of long-term BZ users at the 12-week post-taper follow-up period. No significant effects were observed on withdrawal severity \[52\]. Another research group reports that ten BZ-dependent patients were successfully tapered over a 2- to 4-week period with very limited withdrawal phenomena while being treated with a 300-mg daily dose of trazodone \[3\]. A recent double-blind study has observed that, in comparison with placebo, trazodone significantly improves the BZ taper success rate at the 5-week post-taper follow-up assessment, although no statistically significant effects on withdrawal severity were observed \[52\]. Moreover, one recent controlled study \[70\] suggests that donepezil, in dosages up to 150 mg/day, may help to reduce BZ withdrawal symptoms; the possible efficacy of the drug on withdrawal symptoms appeared to be independent of the antidepressant effect.

Data on the efficacy of Flumazenil in the treatment of BZ withdrawal syndrome are
contradictory and difficult to interpret. Some preliminary controlled studies showed the efficacy of flumazenil in alleviating withdrawal symptoms after abrupt BZ discontinuation in chronic users [21;22;59]; on the other hand, flumazenil has been reported to precipitate panic attacks and dysphoria [26] and cause a withdrawal syndrome [38] in dependent patients who are still taking BZs. A recent double-blind study compared the effects of intravenously-administered flumazenil, caffeine, and placebo in long-term, low-dose BZ users and control subjects. Flumazenil precipitated physiological, self-rated and observer-rated withdrawal symptoms in chronic BZ users, and in some patients caused panic attacks [41].

Partial agonists of the benzodiazepine receptors may have a potential role in the treatment of withdrawal phenomena. Many data suggest a modulation of the BZ-GABA receptor complex after chronic stimulation as the molecular mechanism responsible for the development of BZ dependence [40]. There are some indications that the long-term use of these partial agonists seems to decrease tolerance phenomena and the risks of dependence [64]. However, the only controlled study published so far reported that alpidem was less effective than placebo in helping patients to discontinue Bzs [40].

**Benzodiazepine withdrawal in patients with Anxiety and Mood Disorders**

Recent preliminary evidence, backed by clinical experience, indicates that the long-term therapeutic use of BZs in anxiety and mood disorders is a cause for special concern. Because of their clinical characteristics, anxiety and mood disorders are diagnostic categories that frequently utilize BZs on a long-term basis with a consequently high risk of dependence; moreover, long-term side effects and withdrawal phenomena appear to worsen the clinical features and course in a substantial proportion of these patients [17;40]. As regards anxious patients, this risk mainly involves panic and generalized anxiety disorders. During BZ withdrawal, PD patients frequently experience a rebound of symptomatology: panic attacks are more serious and frequent, anticipatory anxiety gets more severe and avoidance increases [18;11;47]. As a result, the long-term use of BZs can favour the evolution of PD towards a chronic course, just as BZ withdrawal can increase the PD symptomatology and set up a vicious circle of catastrophic expectations, increased vigilance and fear, panic and reinforced BZ dependence. In addition, the long-lasting anxious phenomenology of GAD encourages the prolonged use of BZs, especially because of patients’ self-administration during occasional exacerbations of symptoms. However, in GAD patients seen by a specialist, chronic anxiety concomitant with BZ dependence is often worsened by symptoms such as irritability, depression and insomnia that usually disappear after drug discontinuation. The perceived severity of withdrawal may also be worsened by cognitive modalities towards the drug often seen in anxious patients, such as phobia of side effects, passive dependence or unrealistic therapeutic expectations.

In mood disorders long-term BZ use can induce chronic dysphoric mood, irritability, the persistence of anxiety, difficulty in concentration and memory impairment. During BZ withdrawal manic switches can be observed, as well as mixed states, characterized
by anxiety, tension with psychomotor agitation, depressed mood, insomnia, hostility, anger and aggressiveness directed towards oneself and others.

In many patients with anxiety and mood disorders interepisodic chronicity and residual symptoms often appear to be related to the inappropriate long-term use of BZs. These phenomena are usually relieved by well-managed drug discontinuation. As a matter of fact, some studies appear to show that chronic BZ users who succeed in terminating drug administration for at least five weeks, do significantly lower their anxiety levels [53].

**Benzodiazepine withdrawal in Opioid-dependent patients and/or polydrug abusers**

Abuse, addition and dependence on BZs as well as alcohol, cocaine, or other drugs of abuse is a frequent problem for opioid-dependent patients. BZs abuse was found to be a problem for about 50-60% of patients entering methadone programmes [20;57] and about 30% of patients in methadone maintenance treatment begin to abuse Bzs after entering the programme [20]. In studies of opioid-dependent patients in active treatment, rates of cocaine use as high as 40% or more have been reported. Similarly, heavy drinking is a problem for an estimated 15%-30% of methadone-maintained patients. Comparable data regarding rates of comorbid substance use disorders in patients treated in naltrexone programmes are not generally available. Comorbid substance use disorders require special attention, since treatment directed at opioid dependence alone is unlikely to lead to cessation of other substance use. Treatment is generally similar to that described for individual substances. Increased frequency of behavioural monitoring (e.g., daily breath or twice-weekly urine toxicology testing), intensified counselling and specialized pharmacological treatments (e.g., antidepressants) have all been used with varying degrees of success.

BZs-dependent patients who are also dependent on opioids, should be stabilized with methadone and then gradually withdrawn from other drugs. Efforts to abruptly eliminate all drugs of abuse will not be successful with all patients. In such cases, elimination of the drugs one at a time may be warranted. Use of adverse contingencies, such as methadone dose reduction or even withdrawal, for the continued abuse of sedatives or alcohol by patients in methadone maintenance treatment is controversial. Some psychiatrists believe that requiring methadone withdrawal for persistent drug abuse causes many patients to cease or greatly limit use, while failure to enforce such limits implicitly gives patients license to continue use. Others believe that methadone withdrawal is never justified for patients abusing alcohol or other drugs because of the proven efficacy of methadone in reducing intravenous heroin use, improving social and occupational functioning, and providing the opportunity to continue to motivate patients to reduce other drug use.

Multiple-drug abuse may cause some additional problems for safe withdrawal. BZs are only rarely the primary drugs of polydrug abusers; however, these compounds are often used to self-medicate the adverse effects of cocaine or methamphetamine, to enhance the euphoric effects of methadone or to self-medicate heroin or alcohol.
withdrawal symptoms.

Cocaine abstinence syndrome may mask the occurrence of a sedative-hypnotic withdrawal syndrome, because its features include lethargy, depression, irritability, hypersomnolence and confusion. It follows that during BZ tapering in the presence of recent cocaine abuse, withdrawal symptoms are best detected by increases in vital signs such as pulse, blood pressure and temperature.

When supratherapeutic doses of BZs are abused with large amounts of opioids it is preferable to stabilize the patient on methadone and a long-acting BZ, then start gradual tapering of the latter drug. Opioid withdrawal may begin when the sedative-hypnotic withdrawal syndrome has remitted. If the patient has been taking moderate doses of both classes of drugs, simultaneous withdrawal may be feasible.

Combination with alcohol increases the severity and modifies the time course of the sedative withdrawal syndrome. However, when patients are dependent on a combination of alcohol, benzodiazepines and other sedative-hypnotics, the substitution of a long-acting BZ with subsequent taper is still the preferred detoxification method; a dose of benzodiazepine equivalent to all the sedatives the patient is taking is usually sufficient for safe withdrawal. If even large doses of diazepam are ineffective, phenobarbital substitution may be employed as an alternative.

Some clinicians suggest trying phenobarbital substitution with a subsequent taper for BZ detoxification in cases of polydrug abuse [9;72]. However, this method may be criticized as having no intrinsic benefit. An alternative approach would be to estimate a BZ dosage equivalent to all the sedative drugs taken by the subject and then gradually taper it, as with detoxification from supratherapeutic dosages.

A protocol utilized [72] for switching patients to phenobarbital is the following: the patient’s history of drug use during the month before treatment is used to calculate a dose of phenobarbital equivalent to the benzodiazepine and other sedatives that the patient is taking. The computed phenobarbital equivalence is given as 3 or 4 doses daily. The maximum phenobarbital daily dose is 500 mg. Patients who exaggerate the amount of drug they are using become intoxicated during the first 2 days of treatment and the dosage can be adjusted accordingly. After 2 days of phenobarbital stabilization, the patient’s daily dose is decreased by 30 mg per day. Before receiving each dose of phenobarbital, the subject is checked for signs of drug toxicity (persistent nystagmus, slurred speech, ataxia). If only nystagmus is present the next dose of phenobarbital is withheld. If all three signs are present, the next two doses are withheld and the daily dose of phenobarbital for the following day is halved. If the patient has signs of sedative-hypnotic withdrawal, the dosage should be increased by 50% and the patient restabilized before continuing withdrawal.

Outcome of Benzodiazepine withdrawal

Only a few adequately designed follow-up studies have been carried out on patients who terminated BZ withdrawal. Available follow-up studies suggest that most patients can successfully discontinue these compounds. Abstinence from BZs, 1-6 years after
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withdrawal, varied in different studies between 54% [23], 66% [30], 73% [51], and 92% [6]. Predictors of successful long-term withdrawal include younger age, participation in the taper programme, fewer symptoms at the time of withdrawal and absence of personality disturbances [29;51]. There are contrasting reports on the shorter [51] and longer duration of BZ usage [29] as a predictor of a successful outcome; the latter observation contradicts the finding of more severe withdrawal symptoms in patients taking BZs for longer periods, and could be explained by a lower overall severity of psychiatric symptomatology in their sample. The successful, long-term discontinuation of BZs appears to be a slow process, taking months or years, as a significant number of patients, up to 75%, took BZs after the initial withdrawal (most of them stopped again afterwards) [30]. These results support the observation, in clinical experience, of a protracted clinical course after drug cessation, as patients remain vulnerable to external stresses and experience wave-like recurrences, with symptoms varying in severity and type, over a period of many weeks or months [7;69]. It still remains to be defined if this type of course is to be mainly attributed to the long-time course of BZ withdrawal or to the recurrence of the disorder which prompted BZ treatment. The existence of a protracted abstinence syndrome lasting for months or years is still debated [27]: there is some evidence of long-term cognitive impairments persisting at the 6-month follow-up after BZ discontinuation [67]. Some authors postulated that low-dose, sustained sedative-hypnotic withdrawal is receptor-mediated; this theory would explain why symptoms worsen when patients taper from the last few milligrams of the BZ [72]. It should not be underestimated that many patients undergo BZ treatment to alleviate psychiatric disorders with a generally chronic or recurrent course, such as PD, GAD or mood disorders. It should be borne in mind that a significant number of patients who successfully discontinue BZs still experience significant anxiety or depression symptoms at follow-ups after one to six years [51]. Moreover, 22% of BZ-free patients were taking other psychotropic medications, mostly antidepressants. In any case, it appears that BZ discontinuation significantly improves the clinical situation of chronic users, with a reduction in levels of anxiety [6,53]. This suggests that patients who continue to have significant symptoms of anxiety or depression while taking a benzodiazepine should probably undergo a structured withdrawal programme, with the possible addition of adequate antidepressant treatment. As experience in discontinuation methods increases and better instruments for managing withdrawal symptoms become more widely available, it is likely that the long-term outcome will continue to improve.

Conclusions

Even if BZs still represent a powerful treatment for several psychopathological conditions accompanied by acute anxiety and agitation, serious doubts about their long-term use in chronic and recurrent mental conditions have arisen. In addition to dependence and withdrawal phenomena, the presence of chronic subtle toxicity and interference with underlying psychopathology appear to suggest that a more careful evaluation of the risk-benefit ratio in the long-term administration of BZs is needed. If
treatment with these drugs no longer appears to be strictly necessary to the management of the disorder, a discontinuation trial should be planned and carried out. BZ withdrawal seems to be a protracted process, with important residual psychopathology in a significant number of patients; therefore, the most important ways of obtaining a good outcome seem to be the gradual tapering of doses, the flexible management of a withdrawal schedule, adequate psychological support, a long-term follow-up, and the correct use of adjuvant medications, especially antiepileptics and antidepressants.

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Addiction and methadone: One American's view

Robert G. Newman

Summary

To refer to America’s “war on drugs” as a failure is overly generous. It is a disaster! Other nations should ignore what Americans say and consider instead the consequences of what they do. With specific regard to the treatment of addiction, all modalities that offer hope should be supported. None, however, approaches the proven ability of methadone maintenance to attract, retain and help addicts. Accordingly, the unique constraints on methadone’s availability must be removed, and the general practicing physician given the same authority to prescribe methadone as she/he has to prescribe any other medication.

Key words: Addiction - Methadone - War on drugs

Introduction

Generally I avoid public comment on aspects of addiction that are beyond my particular area of experience – namely treatment, and, specifically, methadone treatment. However, I have come to realize that the many complex factors associated with “the drug problem” are so inextricably linked that one cannot consider any one aspect in isolation. Accordingly, I will preface my remarks on methadone today with some observations on the general status of the “war on drugs” in my country.
**Look who’s giving advice!**

It is not a pretty picture! In fact, the situation is so dismal that it is presumptuous for an American to give advice on drugs to colleagues from other countries. In a way, it is analogous to Bill Gates lecturing on how best to ensure healthy competition in the marketplace, or Iraq’s Saddam Hussein advising on how to live in peace and harmony with one’s neighbors.

To describe the results of our efforts to achieve a “drug-free” America as disappointing is to carry understatement to a new extreme. In cities throughout the United States, the purity of illicit drugs is high and prices low; interdiction efforts at home and abroad have had no impact on the production, importation or availability of drugs; domestic criminal justice activities are hopelessly compromised by corruption at the local and national level; and internationally, there has been the humiliating recent disclosure that the chief of America’s military offensive against drugs in Columbia, and his wife, were involved in shipping drugs to the United States and laundering the profits of this traffic. As for treatment, the proportion of users with access to care is no greater than it was 20 years ago, before the onset of the AIDS epidemic. And on the prevention and education front, the puerile notion that one can rely on the message to “just say no” is the focus of ridicule world-wide, and more ambitious (and much more expensive!) programmes such as D.A.R.E. are generally acknowledged to be ineffective.

The ineffectiveness of our efforts, however, is the least of our problems in America. Far worse is the staggering and ever growing cost that my country bears as a result of the stubborn refusal to stop this tragically futile “war”.

- We now have the distinction of having a greater proportion of our countrymen behind bars than any nation in the world. The Federal Bureau of Investigation reports that in 1995 alone there were almost 1.5 million drug arrests, of which 500,000 were for marijuana possession [15].
- On the home front and overseas, we fight losing battles that cost American taxpayers billions of dollars that otherwise might be devoted to improving housing, education, employment opportunities and access to health care (one of every six residents in the world’s wealthiest nation has no health insurance!). The annual budget for our drug war stands at $ 18 billion (US government Internet site at www.whitehousedrugpolicy.gov/policy/99ndcsbudget/exec.html); this is exactly 10 times the total expenditures of the World Health Organization, and 80 times (!) more than what the World Health Organization spends for all of its activities on the African continent (World Health Organization Internet site at www.who.int/aboutwho/en/qa6.html).
- The United States provides enormous financial and military support to foreign governments for the avowed purpose of waging war against their own citizens.
- Fear and crime are pervasive components of American life. Murders occur at a staggering rate, and our state governments subsequently kill
large numbers of the murderers in retribution, a practice that most civilized nations abandoned decades ago.

Perhaps most distressing of all is the erosion of the cherished freedoms that have always been the pride of American citizens and the envy of others. In states where medical marijuana bills have been placed on the ballot and passed by wide margins, Federal officials patronizingly dismiss the expressed will of the people by claiming they have been “duped”, and do their utmost to thwart the outcome of the democratic process. Police stop, search and harass people selectively, based on “profiles” that seem to reflect racial stereotyping more than anything else. While our justice system has long been known to protect (and punish) some Americans more than others, the inequality is particularly glaring where drugs are concerned. Thus, just last week a report sponsored by the Justice Department found, “For those [young people] charged with drug offenses, black youths are 48 times [sic!] more likely than whites to be sentenced to juvenile prison” [3]. And people who have never been charged – let alone convicted – of any crime have lost their homes, cars and other possessions under “forfeiture” laws enacted centuries ago to deal with pirates!

Happily, the constitutional guarantee of freedom of speech survives, but Government leaders and other champions of the war on drugs vilify Americans who advocate open debate of alternatives to the current zero-tolerance policies. Consider the following statement made last week by the Michigan Drug Free America Foundation: “All across Michigan, individuals and organizations are working to soften our acceptance of illegal drugs in our communities. Some are in it for the money, others for easier access to their drugs of choice. But […] it ends with all drugs becoming legal for all Americans, even our children” [1]. A sad historical precedent seems to be repeating itself. Thirty years ago, blame for the steadily rising toll of suffering and death in Viet Nam was placed not on the nation’s policy-makers or generals, but on the demonstrators whose message was “Peace now!”. Today, those who propose discussing options to the drug war are condemned for “condoning” drug use, and blamed for its continued spread.

And yet, I must say that I am generally optimistic regarding the prospects for drug policy reform in America. There are two reasons for this positive outlook, and they are related. First, America’s uncompromising prohibitionist policies have proven such a dismal, costly and transparent failure that it is increasingly difficult for us to constrain other countries – through persuasion, bullying or blackmail – from pursuing more pragmatic and promising approaches. This, in turn, will gradually but inevitably erode the tolerance of the American people for the obvious folly of our policies, as they become aware of undeniable evidence from other nations that it is possible to reduce for users and for the general population the harm that is associated with drug use.

Methadone treatment - A special case

My optimism regarding a change in America’s drug policies does not, alas, extend to methadone maintenance. Thirty-five years of experience have consistently demonstrated the effectiveness of methadone in reducing – if not eliminating – heroin
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use, and in permitting patients to lead healthy, self-fulfilling and socially productive lives. Clearly, it is not a panacea, but its ability to attract and retain patients and to lessen the consequences of the disease of addiction compares extremely well to the results of treatment of most other chronic illnesses. Effectiveness of methadone had been reported from countries throughout the world, with markedly different social, political and economic environments, and with addicts who use different types of narcotics by different routes of administration. Nevertheless, the overwhelming majority of heroin addicts in America have no access to methadone treatment!

This paradox stems from the fact that all the thousands of medications in the pharmacopoeia, only methadone can be prescribed exclusively by “comprehensive treatment programmes”, and not by physicians in their private offices, in hospital clinics, in community health centres, etc. Collectively, these programmes can accommodate less than 15% of those whom methadone treatment might help [12]. The others are left to their fate, without hope, and the cost of their misery is shared by all Americans.

Lifting the governmental restrictions that effectively preclude the expansion of methadone treatment capacity would require the support of the clinicians and administrators who have the experience and expertise of providing methadone treatment – i.e., those who work in methadone programmes. Unfortunately, nothing suggests that this support will be forthcoming. There has been scattered endorsement of “medical maintenance”, a euphemism for methadone prescribing by private practitioners, but that endorsement has been so highly qualified that it is essentially an irrelevancy. For instance, the American Methadone Treatment Association (AMTA) has described medical maintenance as a “bold but necessary change”. AMTA has gone on to stress, however, that its endorsement is contingent on the following conditions: that every private physician wishing to provide methadone be approved individually by a “methadone programme” and accept only patients referred by that programme. As for eligibility to receive private physician care, AMTA would require that patients have been “physically and emotionally stable [and] completely free from alcohol and drug abuse for a full 36-month period, and that they have been employed for at least three years” [11]. In fact, AMTA’s suggested criteria are liberal compared to some others. In Seattle, Washington (a city that faces one of the country’s worst heroin problems), a “pilot programme” affiliated with a local methadone clinic treats a total of ten patients referred on the basis of having had no evidence of drug use for at least eight years [2]. Surely many applicants for employment in methadone programmes would be unable to meet these criteria!

It is possible that the strong commitment of the leadership of the methadone establishment to the status quo is altruistic, and based on the conviction that the present system – their system – is not only the best, but the only one that merits support. Even if if the motivation of those who fight to prevent change were completely beneficent, however, that is no consolation to the many hundreds of thousands who, as a consequence, will continue to be deprived of treatment.
Furthermore, the woefully inadequate availability of methadone treatment compromises the fortunate few who gain admission no less than the many who are excluded. The problem for enrolled patients lies in the almost unlimited power that programme staff have to give – and to deny – a medication that can mean the difference between life and death, and for which there is no alternative source. Whether or not this power is abused, it certainly permits abuse, and for this reason alone is antithetical to the principles of patient rights that are widely accepted today.

My concerns over the potential for abuse are not entirely hypothetical, however. They are prompted in part by clinical practices that are very widespread in America, and that seem to defy both empirical evidence and common sense. For example, a former Director of the National Institute of Drug Abuse noted that for almost twenty years it has been clear that most patients require a daily methadone dose of 60 mg or more to achieve the greatest benefits. He went on to say, in unusually blunt language, “In this age of AIDS, a low dose policy is not simply inappropriate, but can be fatal to the IV drug abuser in treatment as well as his or her sexual partners and children” [14]. And yet, the majority of patients continue to receive sub-optimal doses of methadone [4]. Similarly, follow-up reports consistently have found that recidivism is the rule rather than the exception after termination of addiction treatment (any treatment – chemotherapeutic or drug-free). Nevertheless, most programmes encourage, or demand, that patients be withdrawn from methadone after an arbitrary period of time, with particular pressure placed on those patients who have responded best to maintenance treatment.

In the absence of either a theoretical or empirical rationale for these patients, one must consider the possibility of a bias on the part of clinicians against the medication, the patients or the disease of addiction. The only explanation one hears is “We don’t believe in high doses or indefinite maintenance!” Of course, clinicians are free to “believe in” or to reject any therapeutic regimen, as they see fit. Their patients, however, must be fully informed of the evidence in support of the treatment approach they recommend, as well as the alternatives, and the risks associated with each. Methadone patients in America do not receive this information, and have no choice in any event since in most communities no other source of the medication exists.

I have referred to detoxification imposed on patients because of the seemingly arbitrary decision by clinicians that at a certain point “enough” treatment has been provided. Patients also face termination for a host of other reasons that are without parallel in the medical management of disease. For instance, renal dialysis would never be stopped because a patient smoked marijuana, or crack, or used other illicit substances. Nor would those suffering from hypertension, diabetes, arthritis, glaucoma, schizophrenia or any other illness be abandoned because they used drugs. How ironic, then, that most methadone programmes, whose express mission is to treat addiction, refuse to tolerate patients who demonstrate the signs and symptoms of drug use!

Nor is it just persistent drug use that leads patients to be discharged from methadone programmes. A recent report describes how unemployed methadone patients, regardless of how well they had responded to the medication, were warned that if they failed to give
Heroin Addiction and Related Clinical Problems

proof of a job within two months their care would be terminated; that is precisely what happened to those who were unable or unwilling to meet the requirement [7]. This example is far from unique. In fact, it has been noted that “Perhaps the most popular intervention used in contemporary methadone clinics is contingent treatment availability. Patients are informed that they will be discharged from treatment if they fail to meet certain treatment requirements [...] [Patients faced with the possibility of losing access to treatment often change behavior to meet programme demands]” [6].

It is interesting to place in perspective the almost total discretion that methadone programmes have in deciding what type of “maladaptive behavior” or other forms of non-compliance warrant termination of care. For example, Federal law in America demands due process before a nursing home can discharge – or even transfer – a resident (US Government: CFR part 431 and subpart E of part 483). To ensure that all nursing facilities in New York adhere to these standards, the State Department of Health promulgated the following requirements: advance notice must be given to the resident and a family member or legal representative, stating the precise reason for the proposed discharge or transfer and spelling out the resident’s right to appeal. If an appeal is requested, it is conducted by staff of the Department of Health, and the resident is permitted to represent him/herself or use legal counsel or a relative, friend, etc.; and the resident is given the opportunity to cross-examine all adverse witnesses [10]. A bit unwieldy, to be sure, but the undeniable reality is that termination of methadone treatment can have fatal consequences. Surely the methadone patient deserves no less protection than the nursing home resident!

While discharge from treatment is the ultimate sanction for failing to meet the clinicians’ expectations, other “contingencies” are widely imposed within the treatment setting. Most involve using methadone dosage as a positive or negative “reinforcer” for different types of behaviour, with increases in dosage used as a reward, and a decrease as a punishment. The incentives often appear to be both counter-therapeutic and counter-intuitive, and occasionally downright absurd. Thus, when there is evidence of heroin use, doses that are less than adequate to begin with are reduced further, and ultimately the patient is terminated; when patients are “clean”, on the other hand, their dosage of methadone is raised [13]. An analogy would be the reduction of a diabetic’s insulin dose when the blood sugar is high – especially if there is reason to believe the patient has “cheated” on his or her diet. Or an increase in anti-hypertensive medication when blood pressure is well controlled – particularly when the normotensive state is attributed at least in part to compliance by the patient with recommendations for exercise, stress reduction, avoidance of excessive salt intake, etc.

It would be presumptuous to condemn any of these practices. Whether they are ethical and appropriate is a judgment each of us can make for ourselves. My point is that precisely the same right to accept or reject such practices must be afforded every addict who seeks and receives methadone treatment, and this will never be achieved until applicants and patients have a choice of provider. Choice, in turn, is precluded as long as methadone is in the hands of a small monopoly of “programmes”, however dedicated
and competent they may be. The only solution is for methadone, like every other medication, to be available from physicians in general practice. Only then will the usual safeguards that apply to all other patients in America be enjoyed by those who need and want methadone for the treatment of their heroin addiction.

Thirty years ago, before the New York City Health Department Programme that I was charged to plan and implement had admitted its first methadone maintenance patient (within two years it had an active census of over 12,000), I expressed concern over the “intermingling of medical and social goals”, and the consequences when “[...] the patient does not seek to adopt what we feel is a desirable pattern of behaviour.” In those remarks, made at the Third National Methadone Conference in November, 1970, I expressed a view that I still fervently espouse: “Medical care should not be withheld except for strictly medical reasons” [9]. The practices of methadone programmes in America have borne out the concerns I expressed so many years ago.

Another speaker at that 1970 Conference was Vincent P. Dole. Dr. Dole provided an emphatic “No!” to his rhetorical question “Is it proper for a judge to force treatment on an addict by sentencing him to a maintenance programme?” [5]. Today, especially in America, we have a new fad – “drug courts” – that do precisely what Dr. Dole decried. The intended consequence, clearly, is that the considerable control already inherent in the unchallenged authority to prescribe a life-and-death medication be made “[...] even more powerful when other contingencies operating outside of the clinic...mandate that the patient remain in treatment” [6].

Dr. Dole went on to comment on the major obstacle to “decentralization of methadone programmes, and, specifically, the inclusion of private practitioners in the system”. He noted “At stake is control over a large programme with a growing budget [...]. Decentralization of services might bring treatment to more addicts, but it would weaken the bureaus. History fails to disclose a precedent in which any bureau has cooperated in a reduction of its power”. I applaud Dr. Dole’s prescience three decades ago, and point out while his reference, as I recall, was to the government bureaucracy, it applies equally to the therapeutic bureaucracy.

Conclusion

In conclusion, I urge above all that we be humble!

• We must have the humility to acknowledge our own failures and the apparent successes of others; we must be willing to give up strategies associated with the former, and emulate the latter.
• We must accept the fact that regardless of how strongly we favour a therapeutic regimen, we absolutely must defer to our patients, precisely as the wishes of patients with other illnesses are paramount, legally and ethically.
• We must acknowledge that, as is true for virtually all chronic diseases, we have a very imperfect and incomplete notion of what causes addiction, and not the slightest clue how to “cure” it.
We must be constantly aware of the unique power that we have over our patients, and strive to be superhuman in controlling the inclination to use that power, even (especially!) when we are tempted to do so “for their own good”.

Our ability to provide effective treatment to heroin addicts who seek our help is an extraordinary privilege! However, it also is associated with a responsibility to do everything possible to make this treatment available, on request, to all. The extent to which our own programmes provide this care is irrelevant; the only thing that counts is getting it to every single individual who needs it, wants it and may well die without it.

And finally, a special recommendation to my colleagues from other countries. Be exceedingly cautious in considering any addiction-related advice from Americans - myself included! If you are going to be persuaded by us at all, let it be on the basis of our experiences, rather than our rhetoric.

Epilogue

At the beginning of this presentation I acknowledged the major credibility problem that I – and all Americans – face in speaking about drugs, given the terribly ineffective results of our nation’s policies. Now, at the conclusion of my remarks, I have another acknowledgement, and one that is far more embarrassing to me personally.

Just before landing in Milan yesterday morning, I was looking through some journals I had brought along for the trip, in order to catch up on my reading. In one publication, which by coincidence is the official journal of this Conference, Europad, I came across an article that summarizes precisely the views on methadone to which I have subjected you this evening. Furthermore, it does so more clearly and far more concisely than I have been able to manage.

I refer to the article by Italian colleagues from Trieste, Drs. Michelazzi, Vecchiet and Cimolino, in which they stated the following:

“The basic idea of a family doctor treating a drug-addict patient is that of acknowledging the patient’s right to health and right to choose, as a sick person who is asking for help”.

That indeed is the goal that should guide all of us! The authors also present their experience, which shows the objective is indeed achievable. Family doctors in Trieste began in 1994 to treat heroin addicts in their private offices with methadone maintenance. Now there are fifty physicians in Trieste who provide this treatment in their private offices, and they have found that “The drug-addict became just a patient once again [...]” [8]. What could be clearer? What could be more logical?

References

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An evaluation study on share care methadone treatment between a specialized clinic and a network of General Practitioners

Anne Coppel

Summary
This article discusses recent changes in France from what has mainly been a repressively oriented drug policy towards accepting and supporting a variety of harm reduction measures. The introduction of harm reduction in the early nineties proved to be very successful in terms of harm reduction and is already a reality. Most officials, however, are still reluctant to support this implicit policy change openly, or work coherently for a reduction of current inconsistencies or admit the overwhelming success those changes have brought about, so the author is afraid of a serious backlash. The positive effects may be threatened if the public is not adequately informed about the new situation and its positive effects. The government may be unwilling to continue supporting harm reduction in the face of increasing public criticism based on ignorance and an inadequate conception of how to preserve public order in connection with illicit drugs.

Key words: Harm reduction - Methadone treatment - Buprenorphine treatment - General Practitioners

Introduction
For more than twenty years (1970-1992), there had been no public debate on drug policy in France. Faced with increasing public concern, politicians – on both the right and left – formed a united front against liberalisation. The State took on the role of protecting citizens against the peril of drugs. The criminal justice system was considered to be the best way to protect public health, whereas treatment was seen as a gesture of leniency reserved for repentant drug users. Politicians were only concerned with preventing an escalation, which the extreme right attempted to foster.

At the beginning of the nineties, a social movement which united a variety of forces...
(activists from the AIDS support group, humanitarian associations, health professionals and peer-support associations) forced the authorities to introduce harm reduction measures in order to contain the AIDS epidemic.

In 1994, the Minister of Health, Simone Veil, took several emergency measures such as permitting needle exchange and legalizing substitution treatments (which until then had been illegal). At that time those harm reduction measures were not really accepted by, or even known to the majority of politicians.

The results of these measures were, however, immediate; within five years, overdoses of heroin decreased by 80% and arrests of heroin users decreased by 57%.

The most recent government plan, announced in June 1999, was the first to declare public health objectives [1]. Alcohol and tobacco have now been integrated into drug policy, in spite of the opposition of unions, representing producers of alcoholic products.

![Graph showing the number of patients undergoing substitution treatment](image)

**Fig. 1. Estimated number of patients undergoing substitution treatment (Siamese source)**
This new strategy has clarified the contradiction between an approach based on public health aims and an approach based on the criminal justice system: a contradiction between a regular increase in arrests (by 87% for cannabis use) on the one hand and, on the other, the inclusion of alcohol and tobacco abuse in drug policy, alongside harm reduction (e.g. needle exchange), together with the penalisation of use. Politicians, except those who are ecologists, are not willing to face this contradiction; they are afraid that harm reduction may lead to irrationally permissive public policies. In these circumstances, it is hardly conceivable that the contradictions can be resolved.

### Empirical Results

Harm reduction projects are now officially recognized in France and treatment centres have to collaborate with low-threshold services which accept that their clients are currently using drugs.

The most striking observation is the dramatic fall of heroin overdoses (505 in 1994, 388 in 1995, 336 in 1996, 164 in 1997, and 92 in 1998. Over five years the decrease has been about 80%) (figures compiled by the Office Central pour la Répression du Traffic...)

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Table 1. Arrests of drug users (OCTRIS Report, 1998)

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<tr>
<td>Cannabis</td>
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<td>41,711</td>
<td>51,043</td>
<td>66,577</td>
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<td>17,356</td>
<td>14,618</td>
<td>11,885</td>
<td>7,469</td>
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<td>1,658</td>
<td>2,075</td>
<td>3,181</td>
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<tr>
<td>Other products</td>
<td>1,405</td>
<td>1,884</td>
<td>1,909</td>
<td>2,188</td>
<td>2,036</td>
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<tr>
<td>Total</td>
<td>52,518</td>
<td>62,325</td>
<td>69,228</td>
<td>82,725</td>
<td>85,507</td>
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Table 2. Trafficking arrests (OCTRIS Report, 1998)

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<tbody>
<tr>
<td>Heroin</td>
<td>3,451</td>
<td>1,356</td>
<td>-60.2%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>3,297</td>
<td>2,920</td>
<td>-11.4%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>721</td>
<td>972</td>
<td>+25.8%</td>
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<tr>
<td>Other drugs</td>
<td>233</td>
<td>199</td>
<td>-14.6%</td>
</tr>
<tr>
<td>Total</td>
<td>8,412</td>
<td>5,541</td>
<td>-34.1%</td>
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Illicit des Stupéfiants [2]).

This reduction occurred as the number of patients in substitution treatments increased. Even OCTRIS agrees that the dramatic decrease in overdoses is due to harm reduction measures.

Methadone treatment was legalised in 1995 and buprenorphine in 1996. During the last five years, the number of patients has risen from less than 100 patients officially under treatment in 1992 to about 66,000 at the end of 1998. This rapid expansion is due to the fact that GPs have been authorized to prescribe buprenorphine. Only about 7,000 patients are having methadone treatment and most of these are not treated by GPs but by specialized clinics (Fig. 1) (Siamese sources).

The main change is the change in medical practices. Drug users have now better access to hospital and medical treatment. The rapid decrease of fatal overdoses shows that there has been an improvement in the health of heroin users. Unfortunately, we have not succeeded in getting national statistics about this improvement. However, we estimate that about 20% of heroin users are HIV-positive and that most HIV patients are now undergoing treatment. But the official recognition of public health priorities has had no repercussions on the repressive approach towards the drug problem. There was a total 91,048 arrests in 1998. Of this number 74,633 were for drug use. This shows an increase of 24% compared with 1996 (Table 1).

During the last five years, the main trends have been:
* an increase in arrests of drug users
* an increase in arrests of cannabis users (62% in 1994, 85% in 1998)
* a decrease in arrests of heroin users (17,149 arrests in 1995 and only 7,469 in 1998)
* a decrease in arrests for drug trafficking (with a fall of 60% between 1996

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</thead>
<tbody>
<tr>
<td>Cannabis</td>
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<td>62.2</td>
<td>66.9</td>
<td>73.7</td>
<td>80.5</td>
</tr>
<tr>
<td>Heroin</td>
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<td>27.9</td>
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<td>14.4</td>
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<td>Cocaine</td>
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<td>2.4</td>
<td>2.5</td>
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<tr>
<td>Ecstasy</td>
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<td>1.8</td>
<td>1.7</td>
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<td>LSD</td>
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<td>0.2</td>
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<td>Opium/morphine</td>
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<td>0.0</td>
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<tr>
<td>Psychotropes</td>
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<td>0.9</td>
<td>0.8</td>
<td>0.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
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</tbody>
</table>
and 1998) (Table 2).

This evolution must be attributed to the fall in the number of arrests of heroin users. According to the drug police forces [2], this fall is partly due to a decrease in heroin use, but this trend is developing quite slowly. The use of cocaine, crack or ecstasy has supposedly been increasing since the early nineties, but this trend is not reflected in the statistics of the drug police forces. One notable event in the last five years has been the sudden withdrawal of 64,000 heroin users from the black market when substitution treatments were developed (Table 3).

The development of public health strategies has, to a large extent, been in contradiction to the criminal justice system: is drug use a health issue (a prevention or care issue) or a criminal issue? On one hand, alcohol and tobacco have been included in drug policy, but, on the other, the number of arrests of drug users (about 85% of these being cannabis users) has been rising steadily.

Various events have recently made evident the incompatibility of the two approaches, which represent two totally different strategies in drug policy. For example, some low threshold services in danger of being closed, mostly because their approach is not consistent with the broader idea of public safety. It is hardly conceivable that the contradictions will be resolved if the government does not decide to clarify the aims of French drug policy.

References:

Received October, 6, 2000
Olof Blix
August 3, 1951 - Uppsala, Sweden

Olof Blix is the Europad representative for Scandinavia since 1994, when the European Methadone Association (EUMA, now EUROPAD) was founded in Geneva. He has been involved in treating methadone patients since 1978, when he started Methadone Programmes in Sweden (Uppsala, Stockholm, Malmo). In 1987-91 he started, and, as a consultant, followed up the first Methadone Programme in Stockholm for HIV-positive opiate addicts at the Danderyd Hospital. In 1994 he became Project Leader for the Oslo Methadone Project in Oslo, Norway. During his stay in Oslo, he was a consultant for the methadone programmes in Lund and Malmo. He was also a consultant for the Malmo programmes from 1989 to 1992. In 1997 and 1998 he participated in several conferences around Norway on methadone, in connection with the government’s decision to start nationwide Methadone-Assisted Rehabilitation Programmes in Norway. Since 1998 he has been Director of the Methadone Clinic at the Bergen Clinics Foundation.

This year the “Chimera d’Argento” Award has been dedicated to the memory of Angelo Gori. He was born in Arezzo on 15 January 1968. He worked in his family firm as a goldsmith, producing new creations, many of which were acclaimed. For years involved in social matters, he was a volunteer of Progetto Aliante. He died tragically in a car crash on 14 April 2000. He left two children.

Progetto Aliante, a not-for-profit organization, has been research and outpatient treatment facility for drug addicts, in Arezzo, Italy, since 1995.
Opioids and cannabinoids abuse among bipolar patients

Icro Maremmani1,2, Stefania Canoniero1, Matteo Pacini1, Antonio Lazzeri1,
Gian Franco Placidi3

Summary
Substance abuse is known to be a risk factor for the development of some types of mental illness, especially in individuals with premorbid vulnerability or psychopathology, but the psychopathology itself may be a risk factor for addictive disorders or a modifier of the course of addictive disorders. In our clinical experience with heroin addiction, the prevalence rates for the bipolar disorder was quite high. More than 50% of the patients had an adjunctive diagnosis of bipolar disorders. In many cases they met the criteria for a diagnosis of bipolar I, bipolar II or cyclothymic disorder. So bipolar I and bipolar II disorders are more frequent than depressive ones. Bipolar patients are well represented among cannabinoid abusers, and schizophrenic spectrum patients among cannabinoid non-abusers. Interestingly, the number of bipolar patients who continued to abuse cannabinoids after the onset of the first episode was higher than that of schizophrenic spectrum patients. In conclusion, our data support the increasing evidence of high rates of co-occurring bipolar and addictive disorders.

Key words: Psychiatric comorbidity - Cannabinoid abuse - Heroin Dependence - Bipolar Patients

The relationships between psychopathology and addictive disorders have seemed to be so complicated that in 1986 Meyer considered this problem to be “another example of the chicken and egg”. He proposed five possible relationships and one non-relationship between addictive behaviour and a coexisting psychopathology. Substance abuse is known to be a risk factor for the development of some types of mental illness, especially in individuals with premorbid vulnerability or psychopathology, but psychopathology may itself be a risk factor in addictive disorders or a modifier of the course of addictive disorders. Some psychiatric disorders may develop in the course of

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### Heroin Addiction and Related Clinical Problems

<table>
<thead>
<tr>
<th>Psychiatric Comorbidity</th>
<th>99 Consecutive Heroin Addicts</th>
<th>PISA-Methadone Programme</th>
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<tbody>
<tr>
<td>BDZ Related</td>
<td></td>
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<tr>
<td>Alcohol Related</td>
<td></td>
<td></td>
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<tr>
<td>Anxiety Disorders</td>
<td>(2)</td>
<td></td>
</tr>
<tr>
<td>Bipolar Disorders</td>
<td>(24)</td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorders</td>
<td>(5)</td>
<td></td>
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<tr>
<td>Dysthmic Disorder</td>
<td>(1)</td>
<td></td>
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<tr>
<td>Depressive Disorders</td>
<td>(7)</td>
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<tr>
<td>Psychoactive Disorders</td>
<td>(1)</td>
<td></td>
</tr>
<tr>
<td>Alcohol Related</td>
<td>(2)</td>
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<tr>
<td>BDZ Related</td>
<td>(1)</td>
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</table>

Fig. 1. Psychiatric Comorbidity in 99 consecutive heroin addicts. PISA-Methadone Programme
substance use or may be one of its results, while drug abuse may modify the course, the response to treatment, the symptom presentation and the long-term outcome of a psychiatric disorder. Otherwise the psychiatric and the addictive disorder may not be specifically related [18].

In this paper we report data supporting the evidence of high rates of co-occurring bipolar and addictive disorders in selected samples (opioid dependent in-patients and out-patients, chronic psychotic cannabinoid user in-patients).

**Opioid dependent patients**

We considered 45 heroin addicts with double diagnosis consecutively hospitalized at the Department of Psychiatry of the University of Pisa. Ages ranged between 23 and

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*Fig. 2 Mood Disorders in 40 consecutive heroin addicts. PISA-Naltrexone Programme*
Heroin Addiction and Related Clinical Problems

38 years (mean = 29), 31 (68.8%) were males. Fig. 1 shows the psychiatric comorbidity of these patients. The prevalence rates for the bipolar disorder were quite high. More than 50% of these patients had an adjunctive diagnosis of bipolar disorders.

We also considered 33 heroin addicts with a double diagnosis of mood disorders consecutively admitted to an out-patient programme. Ages ranged between 19 and 37 (mean = 25), and 23 (70%) were males. Fig. 2 shows the subtypes of mood disorders. 16 patients (48.4%) met the criteria for a diagnosis of bipolar I, bipolar II or cyclothymic disorder.

The high prevalence of coexisting psychiatric disorders among treated opioid-dependents is well known. The most common diagnoses reported in the literature are mood disorders, alcoholism, antisocial personality and anxiety disorders [11; 17; 19; 24]. Our observations indicate that, in selected samples, the mood disorders are those most common in opioid-dependent patients; this finding confirms the data of the previous literature. In particular, bipolar I and bipolar II disorders are more frequent than depressive disorders. In past studies, therefore, the prevalence of bipolar disorders in opioid addicts may have been underestimated [7; 8; 10; 13; 23]. A bipolar II diagnosis

<table>
<thead>
<tr>
<th>Table 1. Associated pharmacotherapy and dosages in Bipolar heroin addicts</th>
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<tbody>
<tr>
<td><strong>Dosages (mg/daily)</strong></td>
</tr>
<tr>
<td><strong>Min</strong></td>
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<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Methadone stabilization dose</td>
</tr>
<tr>
<td>Carbamazepine*</td>
</tr>
<tr>
<td>Valproic Acid</td>
</tr>
<tr>
<td><strong>During depressive phase</strong></td>
</tr>
<tr>
<td>Fluoxetine</td>
</tr>
<tr>
<td>Fluvoxamine*</td>
</tr>
<tr>
<td>Paroxetine</td>
</tr>
<tr>
<td><strong>During manic phase</strong></td>
</tr>
<tr>
<td>Haloperidol*</td>
</tr>
<tr>
<td>Risperidone</td>
</tr>
<tr>
<td>Clozapine</td>
</tr>
</tbody>
</table>

*Caution during induction phase.
*Re-evaluate the methadone dosage if patient is in MMTPs
should be considered especially in depressed patients who are seeking help for drug-related problems.

As to the treatment of patients with a dual diagnosis of opioid dependence and bipolar disorder, we have observed a good response to carbamazepine and sodium valproate in methadone-maintained subjects (see table 1). One problem with carbamazepine is that it may reduce the serum levels of methadone, so sodium valproate may be a more suitable drug. During long-term treatment we observed that, when

<table>
<thead>
<tr>
<th>DSM-IV Axis I Diagnosis</th>
<th>Non users n=45</th>
<th>Past users n=23</th>
<th>Current users n=43</th>
<th>Total n=111</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Induced psychotic disorder, with hallucinations</td>
<td></td>
<td>2 (4.4)</td>
<td></td>
<td>1 (2.3%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>Schizophrenia disorganized type</td>
<td>5 (11.1)</td>
<td></td>
<td></td>
<td>5 (4.5)</td>
</tr>
<tr>
<td>Schizophrenia paranoid type</td>
<td>2 (4.4)</td>
<td></td>
<td></td>
<td>2 (1.8)</td>
</tr>
<tr>
<td>Schizophreniform disorder</td>
<td>3 (6.7)</td>
<td>3 (13.0)</td>
<td>6 (14.0)</td>
<td>12 (10.8)</td>
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<tr>
<td>Schizoaffective disorder</td>
<td>4 (8.9)</td>
<td>2 (8.7)</td>
<td></td>
<td>6 (5.4)</td>
</tr>
<tr>
<td>Schizophrenia undifferentiated type</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Major depressive disorder, recurrent, with psychotic features</td>
<td></td>
<td></td>
<td></td>
<td>1 (2.3)</td>
</tr>
<tr>
<td>Bipolar I disorder, manic episode with psychotic features</td>
<td>6 (13.3)</td>
<td>2 (8.7)</td>
<td>5 (11.6)</td>
<td>13 (11.7)</td>
</tr>
<tr>
<td>Bipolar I disorder, depressive episode, with psychotic features</td>
<td>2 (4.4)</td>
<td>2 (8.7)</td>
<td>4 (9.3)</td>
<td>8 (7.2)</td>
</tr>
<tr>
<td>Bipolar I disorder, mixed episode, with psychotic features</td>
<td>18 (40.0)</td>
<td>13 (56.3)</td>
<td>26 (60.5)</td>
<td>57 (51.4)</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>2 (4.4)</td>
<td></td>
<td></td>
<td>2 (0.9)</td>
</tr>
<tr>
<td>Brief psychotic disorder</td>
<td></td>
<td></td>
<td>1 (4.3)</td>
<td>1 (0.9)</td>
</tr>
</tbody>
</table>
anticonvulsants are associated with methadone, they may be used at lower doses, probably due to a hypothesized mood-stabilizing property of this drug.

**Chronic psychotic cannabinoids abusers**

As regards cannabinoids abusers, even though there is little evidence for the existence of a specific cannabis psychotic syndrome, it does seem clear that this drug may induce or precipitate several types of psychiatric disorders. Many reports have correlated chronic cannabis abuse with schizophrenia-like psychosis [2-6; 9; 12; 14; 20-22]. However, the lack of reliable diagnostic criteria and the symptom-based evaluation of clinical cases in the traditional literature do not allow one to exclude the possibility that cannabinoids may be associated with other forms of psychiatric pathology, such as mood disorders. In fact, besides a variety of symptoms including anxiety, paranoid thinking, hallucinations, apathy and amotivation, the classical clinical descriptions do report symptoms more typical of mood disorders, such as restlessness, hyperactivity, euphoria, explosive and uncontrollable laughter, and a rapid flow of ideas.

In our Department we studied a sample of 111 inpatients consecutively admitted for an acute psychotic episode. They were representative of three main diagnostic groups: the first belonged to the schizophrenic spectrum, and the second to the mood spectrum (in this group all except one were bipolar patients); only one patient had a diagnosis of substance-induced psychotic disorder (see table 2). 66 patients (59.4%) were cannabinoids current (n=43) or past (n=23) abusers. The bipolar patients were better represented among the abusers (57.8% of non-users, 73.9% of past-users, 83.7% of current users), and the schizophrenic spectrum patients among the non-abusers (42.2% of non-users, 26.1% of past-users, 16.3% of current users - chi square 7.32, df 2, p.02). Interestingly, the number of bipolar patients who continued the abuse of cannabinoids after the onset of the first episode was higher (>80%) than that of schizophrenic spectrum patients (about 70%).

**Comment**

There is increasing evidence of high rates of co-occurring bipolar and addictive disorders. Compared with bipolar non-abusers, bipolar patients with substance abuse revealed an earlier onset of the first episode, a more irritable mood, more aggressive behavior, a more chronic course, lithium resistance and a good response to anticonvulsants, such as carbamazepine and sodium valproate [7; 8].

In drug abusers, a diagnosis of bipolar disorder may sometimes be quite difficult to identify. However, data on a family history of bipolar illness, on mood disorders preceding the onset of drug abuse, on the occurrence of a hypomanic or manic response to antidepressants and on affective temperamental characteristics, may be very helpful in making a correct dual diagnosis with very important therapeutic and prognostic implications [1].

An appropriate approach to the diagnosis and treatment of both conditions, especially in heroin-addicted bipolars, may, according to our preliminary data, increase the
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compliance of patients and the rate of those continuing treatment [15; 16].

References


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Pregnant addict care in Methadone Treatment Programs

Richard J. Bilangi

Summary
Since 1992 Connecticut Counseling Centers, Inc. has been providing two models of pre-natal and post-natal care, including obstetrical and gynaecological examinations, and patient education and care, to our pregnant opioid addicts in two methadone treatment programmes in Connecticut, U.S.A. Connecticut Counseling Centers, Inc.’s two pregnant addict care programmes provide a wealth of patient education, nutritional analysis and education, parenting skills training and pre-natal and post-natal medical care, along with comprehensive methadone treatment. The first model provides pre-natal obstetrical and gynaecological exams, primary medical care and a full range of other services within our Waterbury, Connecticut, U.S.A. Methadone Clinic. We have formal linkages to birthing centres at two local community hospitals. Our second model provides counselling, nutritional and parenting skills training in our Norwalk, Connecticut, U.S.A. Methadone Clinic and the obstetrical and gynecological services are provided by cooperative agreement at the local hospital. These two low-cost models have resulted in significantly successful treatment and pregnancy outcomes.

Key words: Pregnancy care - Addiction - Methadone

Statement of Problem
The incidence of drug-exposed newborns has been reported to be from 3% to 50%, depending on the specific patient population, with urban centres tending to report higher rates [7]. Of the 4.1 million drug-abusing women of child-bearing age estimated from the 1995 and 1996 National Household Survey on Drug Abuse, about 3% are believed to continue drug use during pregnancy [3].

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The Office of Applied Studies 1992 National Household Survey revealed that 6.8% of women of childbearing age admitted to having used an illicit drug in the month before questioning [2]. Recent state surveys have shown that between 8% and 12% of women delivering in their hospitals had used illegal drugs at some time during their pregnancy [1; 4; 6; 8].

It is conservatively estimated that at least 5,000 infants are born annually in Connecticut to women who abuse drugs during their pregnancy. It is also estimated that 20% of women in Connecticut seeking prenatal care are drug-dependent.

A study conducted by the University of Connecticut Healthcare Center and the Waterbury, CT Health Department screened urine samples collected from expectant mothers for illicit drugs. The study found that 4.9% of pregnant women presenting for delivery in Waterbury, CT used illicit drugs [5]

Introduction to Connecticut Counseling Centers, Inc.

Connecticut Counseling Centers, Inc. provides the following behavioural healthcare services in its two treatment facilities in Norwalk and Waterbury, Connecticut, U.S. A.

1. Opiate withdrawal programmes
2. Methadone maintenance treatment programmes
3. Intensive outpatient programmes
4. Partial hospital programmes
5. Dual diagnosis case management
6. Non-chemically supported addiction evaluation and counselling
7. Mental health evaluation and counselling
8. Pregnant addict care programmes
9. Women-centred treatment services
10. Transportation
11. Acupuncture
12. HIV, TB and hepatitis education, counselling and testing
13. Vocational rehabilitation services
14. Research
15. Physician office-based methadone treatment – CSAT funded
16. Clinical Trials Network – NIDA-funded

Agency Mission Statement

Connecticut Counseling Centers, Inc. is a not-for-profit corporation that provides a full range of licensed outpatient substance abuse and mental health prevention, education and treatment services to assist adolescents and adults in becoming productive members of society.
Pregnant Addict Care Treatment Programme Overview

Connecticut Counseling Centers, Inc. patients have received intensive medical monitoring throughout their pregnancies while receiving methadone treatment since 1992. Working closely with local hospitals, state of the art care for the mothers has been provided. The Pregnant Addict Care Treatment Program has been designed to provide a wide range of care.

Types of Problems

The pregnant patients we have treated have multiple impediments to normal healthy pregnancies. These women not only have social and psychological problems, they also have severe medical conditions which compound their already high-risk pregnancy. These medical conditions and complications include:

1. Social and psychological problems
2. Medical conditions and complications
3. Sexually transmitted diseases
4. Intrauterine growth restriction
5. Continued substance abuse
6. Hepatitis A, B, C
7. Anemia
8. Nicotine
9. Tuberculosis
10. Diabetes
11. Epilepsy
12. Hypertension
13. HIV/AIDS

Our Two Models

Our Waterbury model provides on site pre-natal obstetrical and gynecological examinations, primary medical care, post-natal care and a full range of other services within our Waterbury, Connecticut, USA Methadone Clinic. We have formal linkages with the birthing centres at our two local community hospitals.

Our Norwalk model provides on site counselling, nutritional evaluation and care, parenting skills training and role-playing, and a full range of other services within our Norwalk, Connecticut, USA Methadone Clinic. In this model, the obstetrical and gynecological services are provided at Norwalk Hospital. These two low-cost models have resulted in significantly successful methadone treatment and pregnancy.

Outcomes

Teaching

Patient teaching is an integral function of the Pregnant Addict Care Program. The teaching includes:

1. The assessment of present nutritional status, and instruction in pregnancy
diet and the importance of prenatal vitamin supplements
2. The importance of proper rest and exercise
3. The child birthing process
4. Early baby care and parenting skills
5. Pregnancy hazards including smoking, substance abuse, caffeine, and environmental hazards
6. Possible withdrawal symptoms in the newborn
7. Breast or bottle-feeding – bottle-feeding recommended
8. Family planning
9. Provision of birth control methods
10. Stages of pregnancy
11. Emotional mood swings which may be evaluated by our psychiatrist
12. Postpartum depression

**Educational Literature**

Educational literature on the trimesters of pregnancy, developmental stages of the fetus, detrimental affects of alcohol, drugs and tobacco, nutrition and life-style changes are provided as well as discussed at each visit. Hepatitis, AIDS, sexually transmitted diseases, as well as other diseases are also discussed in English or Spanish.

**Pregnant Addict Care Liaisons**

Connecticut Counseling Centers, Inc. utilizes the services of Pregnant Addict Care Liaisons not only to provide services on-site, but also to coordinate services at the local hospitals and clinics that provide services to our pregnant opioid addicts. The Liaisons provide transportation for patients lacking transportation and they are responsible for monitoring each patient to ensure she keeps appointments with her midwife or assigned social worker; they also collaborate with the clinic in order to exchange confidential treatment information. A treatment plan is formulated that is acceptable to the patient and will work towards keeping the mother illicit drug-free so that she will deliver a healthy drug-free child.

When our Pregnant Addict Care Liaisons accompany a patient to the hospital, the Liaison stays with the patient through the visit. The Liaison acts as an intermediary between the medical staff and the patient. This ensures that the patient has every question answered in a caring and humane manner without stigma or negative attitude. This approach also means that the patient’s language of choice is used and that she is able to ask all the questions she wants to.

Using the Liaison in this manner has had an ancillary benefit. The professional relationships between the Liaisons and the hospital staff have helped to reduce, if not eliminate, the stigmatized treatment and negative attitudes that female opioid addicts presenting for treatment and birth at hospitals usually experience. There is as much interchange between the medical staff and our Liaisons as there is between the hospital staff and the patient about methadone treatment in general, and in particular, the course of the patient’s methadone treatment. Often the medical staff learns a great deal about methadone treatment and sometimes a negative attitude on the part of the medical staff
is erased.

Bilingual services are available for Spanish-speaking individuals.

**Initial Visit**

An initial visit consists of an in-depth interview usually lasting between 1 and 1 1/2 hours. The interview captures demographic data, menstrual history, medical treatment, contraceptive treatment, health treatment, and type of delivery: caesarean section or vaginal, genetic treatment of both parents and their families, and a history since the patient’s last menses. Psychological and social histories are integrated in the process.

With this accumulated data, the patient’s historical risk status is established. Some risk factors include age (e.g. if in teens), smoking, drug or alcohol use either presently or in the past, physical or sexual abuse history, medical problems, gestational problems (i.e.: diabetes, pregnancy-induced hypertension, hemorrhage, caesarean section, placenta previa, placental abruption, twin or other multiple pregnancies, etc.). Blood work is ordered which includes a CBC, blood type and Rh factor, RH antibody, VDRL, Rubella Titer, Hepatitis B and C screen, HIV antibody titre and sickle cell screen.

**Physical Exam**

A physical exam is then performed by our obstetrician/gynaecologist; height, weight, progravid weight, blood pressure and pulse base line is established. Skin, head, eyes, ears, nose throat, oral, thyroid, breasts, heart, lungs, abdomen, extremities, neurological assessment and a pelvic exam including external genitalia, vagina, cervix, uterus and adnexa and structure surrounding it are assessed. A Pap smear and cultures are taken. The uterus is palpated and a gestational age is estimated, based on the patient’s last menstrual period and uterine size. The pelvis is manually measured to determine the type and dimensions for vaginal delivery. A recto-vaginal exam is performed to rule out tumors and check for movement or anal position of the coccyx bone.

All information is documented on a medical flow sheet. If any abnormalities are found, referral is made as necessary. After the Pap smear, blood and culture results are obtained, follow-up continues. If a patient needs a colposcopy due to an abnormal Pap Smear, the appointment is made at the hospital of their choice for delivery. The same procedure applies for syphilis, gonorrhea, chlamydia, hepatitis, etc. Ultrasound appointments as well as glucose tolerance tests and alpha-feto protein tests are scheduled as indicated. Tuberculosis and HIV testing is supplied by Connecticut Counseling Centers, Inc.. All information is documented.

**Follow-up Visits**

The follow-up visit consists of checking weights, blood pressure, and gestational age by dates, ultrasound and uterine size. Urine tests for protein and glucose are obtained. Edema, reflexes, fetal movement, contractions, vaginal or pelvic pain or pressure, vaginal discharge, fundal height and fetal heart are all checked, and compared with previous results.
This assures our physician that medically the patient is fine and that the pregnancy is progressing on a normal course. How the patient is feeling is discussed as well as how methadone treatment is working for her. Is her dosage adequate? If she is using other drugs or alcohol, the consequences to the fetus if use continues or resumes are discussed. Nutrition, her and the baby’s progress, referrals, vitamins, iron and its importance are discussed, and all questions are answered. The uterus is measured in centimetres at each visit and the fetal heart is checked. If any inconsistencies or abnormalities are observed, the situation is discussed with the medical director, the patient, and follow-up tests are ordered or the patient is referred to the physician.

**Blood Work**

Medical protocol on follow-up visits consists of blood work and repeat cultures at different gestational ages. They are as follows:

- 28 weeks - 1% glucose tolerance test - Rhogam if Rh negative - CBC and VDRL
- 30 weeks - GC and chlamydia cultures
- 36 weeks - CBC and VDRL, Group B Streptococcus cultures

All abnormal results are again followed up with referrals and/or treatment. Each patient is given a diet for pregnancy consisting of the nutritional requirements set by the American College of Obstetricians and Gynecologists. This is reviewed with, and its importance stressed to the patient. Also, suggestions to implement their ethnic foods are offered. Lifestyle changes are discussed and stressed. The patient is encouraged to rest, increase her water intake, stop smoking or at least decrease smoking, and so on.

Lines of communication with the Public Health Department, the Hospital Labor Unit and delivery nurses and doctors, the clinics that serve our clients and the social service agencies are kept open.

**Medical Services**

In our Waterbury facility these services are provided on site by our obstetrical/gynaecological consultant, Dr. John Kaczmarek. In our Norwalk facility these services are provided at the obstetrical/gynaecological clinic at Norwalk Hospital, under agreement with Norwalk Hospital. We would much rather have provided these services on site at our Norwalk facility, but it became extremely difficult to contract with an OB/GYN in Norwalk. We then successfully negotiated with Norwalk Hospital. Our Norwalk Pregnant Addict Care Liaison transports the patient to the Norwalk Hospital Clinic. The Liaison stays with the patient through the visit. The Liaison acts as an intermediary between the medical staff and the patient to ensure that the patient has every question answered in her language and is able to ask all the questions that she wishes. The use of our PAC Liaison as an intermediary has almost totally eliminated the stigmatized treatment and negative attitude that female opioid addicts presenting for birth usually experience.
Appropriate Dose

An appropriate methadone dosage is the keystone to successful birth outcomes when providing care to an opiate-using patient. An appropriate methadone dosage prevents the onset of withdrawal for twenty-four to thirty-six hours, eliminates craving, and blocks the euphoric effects of self-administered narcotics. (5)

Dosage review during pregnancy should reflect the same effective dosing criteria used for non-pregnant addicts. Sometimes pregnant addicts will need their dose increased in the later stages of pregnancy in order to maintain the same plasma level and to remain withdrawal-free. In the past we used to work with the patient to reduce her methadone dosage as much as possible, as long as the patient continued to remain comfortable and opiate-free. We no longer do that, primarily because the purity of heroin in the United States has increased significantly and higher methadone dosages have been required over the past few years to achieve a blockade. Three years ago it was unusual for us to medicate someone over 100 mg in Connecticut. Now we have non-pregnant patients on 145 or 150 mg of methadone.

Funding

Funding for our Pregnant Addict Care Programs has come from a variety of sources. We began our Waterbury PAC Program with a grant from the Sanford C. Bernstein Foundation in New York City. Total funding from the Bernstein Foundation from 1993 to 1999 totalled $41,905, an average of approximately $5,986 per year. We have been able, with this funding, to pay our OB/GYN M.D. consultant $100.00 per hour, our PAC Liaisons $25.00 per hour as well as pay for the blood work and other testing required.

To implement the PAC Program in our Norwalk facility we received funding from the Norwalk United Way for $3,000 in 1995, $3,000 in 1996 and $2,000 in 1997. Since most of the medical services are provided off site, this is a lower cost model than our Waterbury model. Funding streams from these sources have ceased. We now support the services within our Methadone Maintenance Budgets.

Measurable Treatment Outcomes

The goals of the pregnant addict care programmes are:

1. To decrease the incidence of low birth weight babies of less than 5 lb 8oz.
2. To decrease the incidence of substance abuse during pregnancy.
3. To increase the gestational age of the pregnancy to full term.

Treatment Outcome Review

We will review the outcomes of a sample of twenty-seven pregnant women who sought treatment in our Methadone Treatment Clinics. Twenty-six of these women received pre-natal care at our two facilities. One woman received her pre-natal care entirely from her private physician.

We will review the birthing outcomes of nineteen of the twenty-six women. The remainder had not given birth at the time of this presentation. The ages of these women
range from 20 to 40 years of age. The ethnic backgrounds of the twenty-six women are: 14 White, 11 Hispanic, 1 Afro-American.

Three of the nineteen deliveries were low-birth weights, although close to the five pound, eight ounce cut-off. One weighed 5 lbs. 6 oz. and two weighed 5 lbs. 2 oz..

Additionally, sixteen women delivered babies with birth weights between five pounds eight ounces and seven pounds.

The gestational periods ranged from 34 to 40 weeks. 10 infants, or 56%, received medication for withdrawal symptoms. 2 infants had a positive urine toxicology test for drugs. 95% of the infants were discharged to their mothers, while one infant was taken into custody by the Connecticut Department of Children and Families. 2 women continued to abuse illicit substances throughout their pregnancies. 24 of the 26 women remain illicit drug-free.

In conclusion, the Methadone treatment and the Pregnant Addict Care that these patients received from Connecticut Counseling Centers, Inc. positively affected the majority of the women served by our pregnant addict care programmes.

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Received September, 20, 2000
Aprohibitionism, a feasible way forward

Andrea Michelazzi

Summary

Drug (ab)use is a phenomenon that has continued to advance in western and westernised society, starting at the end of the sixteenth century and the beginning of the seventeenth. In the same period a capitalist form of society developed out of a mercantile one. Psychiatric disease can be viewed as representing the failure of production based on the division of work; similarly, disease connected with addiction can be seen as representing the failure of reproduction resulting from work mechanisation.

The legal idea of a danger to society, once linked to mental disease, survives in the case of drug dependency, and it conditions what is often called policy of damage reduction. Current policies are failing to solve the problem. Drug abuse is spreading, and is causing many deaths, as well as many severe viral infections. Prisons are full of drug addicts. Organised crime keeps getting wealthier, and it recycles its profits; the spread of drugs continues apace, and crime connected with drug-dealing is still thriving. Prohibitionism and antiprohibitionism now confront each other in the political arena.

To find a way forward, it may be better to talk of aprohibitionism, where a distancing effect can be perceived at first sight - in the signifier. In practice, this means there is a need to devise ways of thinking that go beyond the logics of prohibitionism and antiprohibitionism.

Key words: Drug Addiction - Prohibitionism - Antiprohibitionism - Aprohibitionism

Before explaining what I mean by aprohibitionism, some comments are called for in order to clarify the subject.

First it is important to point out that drugs and their abuse have continued to advance...
Heroin Addiction and Related Clinical Problems

in western and westernised society, starting at the end of the sixteenth century and the beginning of the seventeenth. In the same period a capitalist form of society developed out of a mercantile one. Drug abuse is spreading; each drug has its own special effects, and has a specific potential toxicity and capacity to induce addiction. All this is taking place alongside the development of capitalist society. Currently the number of people who consume, and have become addicted to, the various drugs on the market (cannabis, tobacco, cocaine, alcohol, amphetamine and ecstasy) can be estimated at many millions. Other substances, which are not exactly viewed as drugs, such as some psychomedicines, and even some kinds of food and drink, arouse such strong form of attachment in the consumer that they create a degree of dependence similar to that exercised by drugs. Videodependency, pornophilia and possibly some sexual habits are behaviours in which one can detect features characteristic of the behaviour of an addict. This is no coincidence.

In Enlightenment thinking, with its exaltation of reason, goods become the object of economic exchange. What has emerged is a division and mechanisation of work that has clearly favoured the evolution of a society, which, besides being dependent on money and consumption, is becoming more dependent in a broader sense. A kind of counterpoint has been set up, where unreason, after being driven out through economic and intellectual violence, has subtly found its way back through a structural connection with the social system that had expelled it. The capitalist system evolves, and so do the forms of abuse that are practised within it. Economics can no longer be discussed in a purely traditional way, as the commercial value – or worth – of goods has become largely irrelevant. A high price may confuse the public and give an object a symbolic status. In other words, the structural value both of goods and their abuse creates a need for stimulants that induce “self-confidence”. The division of work has turned out to be mechanised work, while alienation has turned out to be expropriation. The fetishistic side of money, which is viewed as implying production relationships other than their apparent features, has evolved into the present phase, where goods have become the object of economic exchange, in an obscene situation where the seduction of goods has become overwhelming, and fascination and subjection, which should be peculiar to reproductive relationships, have come to the forefront.

Three stages can be recognised: religion as the opium of peoples; opium as a religion in its own right; and the present day current cult of chemical ecstasy. Psychiatric disease can be viewed as representing the failure of production based on work division; similarly, disease connected with addiction can be seen as the failure of reproduction resulting from work mechanisation.

The same repressive ideas and the same operative instruments found in the field of drug addiction are paralleled by the criminalization of psychic needs, and the violence of the practices used to manage them: prison as the legal solution, communities as the reeducational solution, and public health services as the medical solution.

The underlying intention is the same – that of managing and suppressing any form of derangement that, as derangement, cannot be perceived as an integral part of the
dominant values of a certain society at a specific moment in history. In the case of capitalist society, every kind of failure of productivity based on the division of work was seen as “abnormal” and “sick”. The form given to “illness” and its therapeutic instruments were, and in part still are, functional to the preservation of the dominant system. Lunatic asylums, shock treatments, malarial and insulin shocks, criminal lunatic asylums and the excessive use of psychomedicines are just a few examples.

The failure of reproduction, taking shape as addiction, has assumed a different form and is linked with satisfactions beyond the range of consumer goods, and with alterations to states of consciousness. It is no chance that the penalised drugs are those that create an alteration to states of consciousness or allow access to pleasure. The degree of dependency or toxicity is not all that important; tobacco, and alcohol as nourishment, are emblematic examples.

The legal idea of a danger to society, once linked with mental disease, survives in the case of drug dependency, and it conditions the policy known as damage reduction. Its real aim is that of reducing the effects of a danger to society implicit in the figure of the drug-addict, compared with the damage he might inflict to himself or on “sound” society.

Ideas like these have clearly had a deep influence on the ambiguous health service and welfare policies of the Jervolino-Vassalli Act in Italy, thanks to which dependency shuttles between prisons, and community and public health services, which have become organised as “drug-addict asylums”. Only the 1994 referendum made it possible to have a form of medical care slightly better attuned to different needs., but an attempt is now being made to cancel its effects.

It is clear that current policies are failing to solve the problem. Drug abuse is spreading, and is causing many deaths, as well as many severe viral infections. Prisons are full of drug addicts. Law courts are jammed with penal and civil trials over drugs, and the large-scale selling of drugs has only been checked to a very limited extent. Organised crime keeps getting wealthier, and it recycles its profits; the spread of drugs continue apace, and crime connected with drug-dealing is still thriving. Public expenditure is high in this field, but the results are very limited.

It is imperative to realise there are real needs and real problems, and that repressing them has not worked and will not work. I therefore consider it a social duty to begin considering alternatives. Prohibitionism and antiprohibitionism confront each other in the political arena

I would like to bring out some parallels that may allow a better understanding of the aprohibitionistic point of view. Antiprohibitionism stands to prohibitionism as free trade stands to protectionism. Free enterprise as the freedom to make profits can be seen as a mirror image of the freedom to take drugs, as a libertarian perceives the issue in its most extreme forms.

Just as anarchy can be seen as a kind of liberalism without a state-run policy force, antiprohibitionism in its extreme forms points to the idea of “anything goes”.

The degree of protectionism regulating the market runs closely parallel to the degree
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of prohibitionism whose limit is reached in an absolutist idea of the ethical state, where protectionism and prohibitionism attain their most powerful expression. The antiprohibitionistic and prohibitionistic parties draw their strength from the emphasis that falls either on the individual freedom to pursue and satisfy one’s needs and desires, and get answers to one’s problems, or on the ethical and moral drive to exercise a sufficiently strong degree of control for civilisation to develop. This is an impasse. The antagonism of the two ideas is such that each position can assert its authority or discredit the other on a number of equally legitimate grounds. In practice, we must recognise that the prohibition party has failed.

Antiprohibitionism offers an alternative way forward, but is not the only choice, and may not be the winning one. It might even be dangerous. Putting a freely sold type of good on the market automatically means setting it in a logic of profit and high sales – of promoting demand; it may easily mean spreading the use of drugs or even shifting the profit motive from an illegal to an authorised domain. We know how narrow the difference is, in the logic now dictated by the global marketplace. Yet antiprohibitionism is not the only viable alternative to prohibitionism; it is its other face and its necessary opposite number. In a dialectical perspective one might be taken into consideration a synthesis that mediates between the two, but even this position does not seem to me a winning solution, in the same way as critical thought is no longer enough to work the present situation out.

A qualitative more forward is necessary, one that goes beyond their confrontation, and beyond the stances both of antiprohibitionism and prohibitionism. What I mean is a standpoint specifically different from the these two – prohibitionism and antiprohibitionism, keeping them at a safe distance and distancing itself from them, while stripping them of their raisons d’etre and their opposition. I therefore prefer to talk of aprohibitionism, where a distancing effect can be perceived at first sight – in the signifier. In practice, this means there is a need to devise ways of thinking that go beyond the logics of prohibitionism and antiprohibitionism. This requires us to think up a procedure which does not legalise drugs in order to make them marketable. It means thinking up a procedure that makes it possible to cope with needs beyond their immediate expression or enforced medical treatment, but also beyond any possible increase in their supply. It means viewing the potential consumption of desired substances in a way that will aim to keep them outside the exchange market. It means stripping a particular type of goods of their most conspicuous features, so allowing both the lawfulness of what stands outside the production-reproduction logic, and a distancing from any course of action that can be evaluated directly in terms of public consumption. To achieve this, I believe that we must distinguish between substances according to their specific noxiousness, on the grounds of the degree of dependency they induce, but also of their actual toxicity and the degree of alteration to states of consciousness they produce.

On this definition, cannabis could be a substance that, in my opinion, could be grown legally. People could freely grow it for personal consumption, and its therapeutic use
could also be permitted via a medical prescription, and/or through some form of state monopoly. The controlled administration of heroin for therapeutic purposes would be the best response to heroin dependency (but only for patients for whom other treatments would not be appropriate). Depenalization belongs to the aprohibitionistic idea in the broadest sense, while it could be necessary to devise strategies of controlled distribution for substances that are very clearly noxious, such as alcohol, tobacco, ecstasy and cocaine. Such distribution should, of course, be organised as a state monopoly, on a “no profit” basis, together with the adequate provision of information, with an objective of prevention and education.

I am making these proposals to encourage further discussion, but I hope that this paper has managed to give a clear picture of what I call aprohibitionism, an idea which could be applied on a wider scale than that confined to drugs alone.

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DE L’HUMANISME AU BIO - COMPORTEMENTALISME ?

LE 5° COLLOQUE INTERNATIONAL TOXICOMANIES, HEPATITES, SIDA
GRASSE, FRANCE 11/15 septembre 2001

Sous le Haut Patronage de Madame Dominique Gillot
Secrétaire d’Etat à la Santé et aux Handicapés

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L’ambiance générale n’est plus à l’humanisme; le monde contemporain de la
toxicomanie s’est pourtant formé dans ce moule humaniste il y a une dizaine d’années,
formant un groupe soudé, une sorte de tribu qui a réuni des professionnels de santé et
des personnes touchées par la toxicomanie. Ils voulaient non seulement mettre en place
les meilleurs moyens pour réduire l’épidémie de l’usage de drogues et de ses conséquences
morbides et mortelles mais aussi intégrer cette problématique dans une politique de
solidarité et d’ouverture vers l’autre. Ce groupe, cette tribu était loin de n’avoir qu’une
vision thérapeutique ; il voulait insérer la toxicomanie dans la médecine, dans la science,
dans la société et donner la main aux usagers de drogues qui le souhaitaient et leur
proposer non seulement une aide pour abandonner les drogues dont, seuls, ils ne
pouvaient se passer mais aussi un retour dans un monde accueillant et bienveillant qui
accepterait la citoyenneté, les différences et la qualité de chacun.
Hepatitis C infected patients and higher doses of methadone

Lubomir Okruhlica and Danica Klempova

TO THE EDITOR: An interesting article [1] and the inspiring paper on the treatment of patients with HCV have appeared in your journal [4]. There is no scientific evidence of hepatotoxicity associated with usage of opioids in general and during methadone treatment in particular [1-3]. Hepatitis C virus antibody is prevalent among patients in methadone maintenance treatment programmes and, as reported by Maxwell and Shinderman [4], patients infected with HCV require significantly higher doses of methadone than non-infected ones. It is possible to test this hypothesis only in the programmes where there is no upper dose limit for MMTP.

We have decided to verify this finding in our retrospective clinical survey among the patients of our MMTP in Bratislava. All the patients (n=105) who had participated in the MMTP for over a year have been included in the comparison. They were chosen for the time period 1998-2000 and their daily dose of methadone was recorded (retrospectively) at the completion of 12 months in the programme. 79% were males and 21% were females. Their average age was 25.0 (SD=6.0, ranging between 17 and 44 years). There is no upper dose limit in this MMTP, and a bell-shaped curve of cumulative frequencies was drawn from the various daily methadone doses (see figure). The patients were divided into two groups according to their serological status: a) patients, who were negative for HCV antibodies (n=46) and had an average daily methadone dose of 105 mg (SD=56), b) patients, who were tested as positive to HCV antibodies (n=59), with an average daily methadone dose of 136 mg (SD=60). No differences were found in basic demographic characteristics between the two subgroups. A statistically significant difference was found between the averages for daily methadone doses in the comparison between two subgroups (t=2.678; p<0.01). Our clinical data support previous findings on the need for a higher daily methadone dose by patients with HCV seropositivity. We can only speculate with Maxwell and Shinderman [4] that the possible reason for higher doses of methadone among HCV+ patients could be determined by an induction of the
Cytochrome P450 enzyme system during HCV infection.

References


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ECCAS publicity officier

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Introducing the
European Collaborating Centres in Addiction Studies
(ECCAS)

Fabrizio Schifano

Although formally named only in 1992, ECCAS was established in 1988-89. Its origins and subsequent development can be traced back to discussions held with officiers of the European Commission in 1987-88, identifying the need for a collaborative study to investigate the treatment of opiate addiction.

In 1991 a contract was signed for the first Multi-Centre Study in Europe to investigate ‘Methadone Substitution Therapy and its Impact on HIV Risk Behaviours’.

Since this first collaborative piece of work, ECCAS has moved on, welcoming new members to its growing group, developing other areas of interest such as training/education, and providing a supportive environment in which members can seek out and discuss with colleagues across Europe a range of issues such as research, education and clinical/treatment protocols.

With an already established code of practice, ECCAS formalised its constitution at its 3rd Annual Assembly in Paris, France, in April 1995.

What are its main objectives?
I. To advance current knowledge in the field of substance misuse through academic and action research activities.
II. To develop practical approaches and methods to prevent and deal with the problems of substance misuse.
III. To disseminate findings of research and good practice across Europe.

What are the advantages of being a member of ECCAS?
The benefits of being a member of ECCAS are multifold and need to be explored. Small groups can become very influential and ECCAS has a role to play within the international arena.

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What are the characteristics of the partners we are looking for?

- It was agreed that full ECCAS members (only institutions, and not individuals, can be members) should be recruited from within European boundaries and should have a strong base in the addictions, preferably with an important research component in their work.
- Countries located outside European boundaries can be invited as ‘associate members’.
- Only two centres per country are permitted to join the ECCAS assembly to ensure parity among members.
- Suggested countries which need to be targeted are: Holland, Greece, Sweden, Norway, Finland, Belgium, Turkey.
- Ex-Soviet States can also be considered, as many are in the process of applying for European Membership.

If you want more information about ECCAS, double click on its logo at the following URL address (where you’ll find the ECCAS constitution and the addresses of its members); http://www.ussl12.bergamo.it or write to the following address:

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Tribute to Josh van Clemm von Hohenberg

18 April 1941 - 15 March 2000

My friends and colleagues will attest to the fact that I am seldom at a loss for words. And yet, it simply is not possible in a few paragraphs to do justice to my respect and admiration for Josh. He was extraordinary in many ways: his friendly nature; his untiring efforts for those who most need help and who all too often are abandoned; his sense of humour, thoughtfulness and sensitivity.

For me personally, I must admit it would have been enough had Josh “only” fought for the expansion of methadone treatment. But his objective was far broader – he sought to ensure that an entire “PALETTE” of services would be available for those whose very survival depends on it.

Josh was enormously successful in his work. Nevertheless, I believe – and I am convinced Josh would agree fully – that his biggest and most difficult challenge was to have a street in the city of Hamburg named after the co-developer of methadone maintenance treatment, Dr. Marie Nyswander. The seemingly endless bureaucracy with which he had to deal (including the “special office for planting of street trees”!) became the subject of a joke between us. In fact, however, success required unbelievable effort, stubbornness and Josh’s absolute determination to allow nothing and nobody to deter him.
As we know, he ultimately did indeed prevail, but that is not the end of the story. Following the agreement of the Hamburg officialdom to create a “Marie-Nyswander Strasse,” Josh had occasion to attend a conference in the United States, and, despite the inconvenience and considerable personal expense, he made a one-day side-trip to California. His purpose: to visit the then 100-year old, bedridden but mentally competent (we should all be equally competent!) mother of Marie. He brought along – all the way from Hamburg – a replica of the original, very heavy, metal street sign, which measured about one and a half metres. He presented this to the mother, who had it hung on the wall in front of her bed. This tribute to Marie, her only descendent, cheered and comforted her until her death shortly after her 104th birthday.

All of Josh’s friends and colleagues have suffered a great loss as a result of his untimely death. However, we can consider ourselves fortunate to have had the honour and the pleasure of knowing him, and the privilege to work with him. We will never forget him, and will always draw inspiration from him.

Robert J. Newman
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