Heroin Addiction and Related Clinical Problems

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2. to enhance the provision and quality of services to drug abusers and their families, especially heroin addicts;
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4. to promote collaborative research and to provide a European research centre;
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Harm reduction and specific treatments for heroin addiction.
Different approaches or levels of intervention?
An illness-centred perspective

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Summary

So far, harm-reduction campaigns have focused on the personal and social needs of heroin addicts, with the aim of preventing the consequences of addictive behaviours. An unduly sharp dichotomy usually seems to come to mind when harm-reduction interventions are compared with specific treatments for heroin addiction. In reality, some of the specific targets in the treatment of heroin addiction, as well as features of mentally ill subpopulations, may be reasonable targets for harm reduction, too. Convergence on overlapping targets may be hypothesized as long as harm reduction and specific treatment come to share the same therapeutic instruments. Opioid agonists, the primary option for the specific treatment of heroin addiction, are also valuable as harm reduction instruments, as long as harm reduction is conceived of as a means for acting on that disease, but only at a low-threshold level. The personal and social impact of possible agonist-mediated harm-reduction seems to carry special weight in higher-risk populations, such as mentally ill heroin users, who have turned out to be sensitive to therapeutic opioid agonism. Harm reduction can best be regarded as a low-level approach to more severely disabled subjects, bridging the gap between the street and clinical settings by a sub-therapeutic but specific pharmacotherapy. Stepping up from harm reduction to a higher level of intervention should, in fact, be the ultimate goal of harm reduction. Transition to specific treatment is particularly important for dually diagnosed addicts, who can be expected to receive a relatively greater benefit; without that transition, they are likely to quickly lose the opportunity to attain a positive outcome.

Key words: Harm reduction - Low-threshold/High-Threshold Approach - Agonist treatment - Dual Diagnosis
Harm reduction: present role and targeting

Harm Reduction is a mode of intervention that works through a low-threshold approach [9]. This mode is meant to reach out to every single subject who is diagnosed as afflicted by heroin addiction, so to give everyone a chance to improve their condition and lessen the risk that arises from addictive practices. The expected quality and weight of the achievable improvement do not represent a criterion for treatment eligibility. In fact, harm reduction aims instead at the fulfilment of the social and personal needs of heroin addicts, rather than targeting addictive behaviours that must be led towards extinction. By contrast, specific treatments are meant to induce the reversal of the core thought and behavioural abnormalities which underlie addictive behaviours - craving and behavioural reinforcement [2; 8; 10]. In successful treatments, maladaptive behaviours and social maladjustment reverse, once the stable control of craving and drug-seeking has been achieved. Specific treatments are expected to benefit the social and relational aspects linked with addiction in a direction favourable to global and progressive readjustment, whereas harm reduction alone cannot be thought to have an impact on the natural course of addiction [13]. In other words, ex-addicts may build around themselves a brand new functional web of relationships, while socially assisted addicts who are still on heroin are unlikely to break away from the substance. Traditionally, harm reduction has been focused on the social and personal needs of the addict, as expressed by the patient or as perceptively witnessed by those approaching him. This may be called a patient-centred harm reduction philosophy. However, harm reduction may also comprise aspects which interact with the dynamics of drug addiction and the feasibility of therapeutic interventions. These aspects are closer to the core of the addictive pathology itself rather than emerging from the patient’s contextual problems, and are the ones to be taken into account in what we have put forward as an illness-centred harm reduction philosophy.

The philosophy of therapeutics: integrated web vs. hierarchical pyramid

There has been a growing wish among clinicians for the development of an integrated model of intervention, accounting for and targeting the various drug-related issues, and leading to a global solution for addictive conditions, consistently with a multifactorial model of pathogenesis. By contrast, we believe that the medical, psychiatric, psychological and social issues of heroin addiction require something more specific than integrated intervention [4; 12]. To effectively treat addiction, rehabilitation and/or prevention is undoubtedly necessary, but one principle to be followed is that of treating patients on the basis to the stage of their illness. It is often necessary to adapt an intervention to the clinical phase of illness, by trying to raise the programme “retention rate - an objective indispensable to even making a process of rehabilitation credible. The nature of drug addiction itself often makes it necessary for patients to be contacted in the street, so that they can benefit from counselling and harm reduction. It is our opinion that different modes of approach to heroin addiction should share the same
philosophy, and that they should represent levels of a hierarchical pyramid, whose top level is the stable control of addiction. Prevention comes first, to target youth at risk before any substance use is initiated. Harm reduction comes immediately afterwards, as a means to buffer the contingent damage done by heroin addiction and prevent further damage. Once partial control has been achieved, diagnosis can be clarified (level three), and therapeutic decisions can be rationally taken (level four). At present, harm reduction is mostly a last resort that is adopted only when no other treatment is considered feasible. In this framework, like the one we have briefly illustrated above, harm reduction looms as a treatment stage, which may sometimes be skipped, but, at least in the case of highly disabled heroin addicts, is a necessary transitional stage on the way to accessing full-potential therapeutic options.

New targets for harm reduction: core addictive symptoms and independent psychopathology

Successful treatments for heroin addiction (i.e. agonist maintenance) have been shown to work by controlling addictive automacy, along with heroin-induced and independent psychopathology, in clinical settings [3; 5; 6]. We suggest that the same therapeutic means, if set in a different context, may be effective within a harm-reduction model, to improve the background and surroundings of the street addict. In fact, while the administration of therapeutic dosages of methadone leads to the accomplishment and subsequent maintenance of a heroin-free condition, the controlled administration of sub-therapeutic dosages may decrease the severity of addictive behaviour and psychopathology. Although the core dysfunction underlying psychopathological symptoms cannot be expected to be superseded, psychopathological crises and peaks may be controlled, so limiting the known disruptiveness of mental disorders such as bipolar ones, which appear to be quite frequent among heroin addicts [1; 11]. Similarly, some harmful addiction-related behavioural alterations may be blunted, including craving-related urgency, impulsiveness and acting out. A change of that kind, even if partial, may help to improve addicts’ compliance with harm reduction campaigns (which aim to reduce risk behaviours as the source of harm). Moreover, the attenuation of a patient’s psychopathology may favour his or her insight, so increasing the likelihood of a spontaneous application for high threshold programmes, besides buffering early attrition phenomena. For instance, the decrease in severity of psychotic and paranoid symptoms may allow the patient to preserve a functional contact with the environment, besides adapting to the rules of structured clinical programmes. In the same way, when violent or psychotic patients are immediately directed to high threshold facilities, they are likely to fail in adapting to their rules, or in doing this within the required time limit.

Apart from its impact on therapeutic outcome, harm reduction as a level of intervention may be useful on grounds of diagnosis. The psychopathological symptoms of heroin addicts are mostly factitious, because they are linked with withdrawal or intoxication states, or are occasionally masked by ongoing methadone treatment at
adequate dosages. Some psychiatric disorders may therefore be overrated in the early phases of treatment in relation to a condition of opioid impairment (i.e. anxiety and depression), whereas some others - those that are opioid-sensitive (i.e. delusional, anxiety or oddity) - are likely to persist unrecognized after stabilization. Low threshold interventions may compensate for gross drug-induced opioid impairment, so making it possible to identify addictive brain disorders before full-dose agonist treatment is undergone.

Thus, low- and high-threshold interventions should converge to achieve an illness-related goal, that is, the extinction of addictive behaviour. Low-threshold approaches may serve as a facility specifically intended to target highly disabled populations, in order to enable them to benefit from high threshold, specific medical interventions. To the extent that those within working groups develop these two approaches while sharing a single philosophy, means for the specific treatment of drug-addiction as an illness may also become powerful means for intervention within harm reduction strategies.

Harm reduction by agonist administration to dually diagnosed patients

The PISA-SIA group runs an agonist treatment programme which aims to meet the criteria for a successful specific treatment rather than the patient’s requests for contingent social or personal problems. The programme’s entrance threshold is raised further by the fact that the programme takes place in a psychiatric setting, unconnected with the nationwide local services for addictive diseases. Patients enrolled in the PISA-SIA Methadone or Buprenorphine Treatment Programmes mostly belong to one of two categories: dually diagnosed heroin addicts resistant to standard pharmacological treatments for mental diseases and uncomplicated heroin addicts who have shown resistance to standard treatment for heroin addiction (i.e. dose-limited or duration-limited treatment programmes). However, once patients have been stabilized, a move is made to a low threshold maintenance; this means that there need be no limitations to duration of treatment or persistence of higher dosages, even over the long term.

In this context, high methadone doses have been shown to be effective in achieving stabilization for more aggressive subjects [7]. In other words, high methadone dosages are effective in stabilizing highly aggressive dysfunctional addicts. As regards typology of aggressive behaviour, methadone impacts best on assault, dysphoria-irritability, hostility and verbal aggression. Aggressiveness is a crucial issue within the perspective of harm reduction, because much of addicts’ sociopathy is the result of their violent behaviour and their negative attitude towards their environment deriving from acquired opioid impairment. On the whole, it is reasonable to suppose that methadone, apart from its effectiveness in treating addiction itself as the source of all personal and social problems, can reduce aggression-related harm. Besides, the reduction of aggression could make those addicts suitable for illness-targeting therapeutic programmes.

Apart from aggression, when viewed in its psychopathological dimensions, psychiatric disorders too represent a limit for afflicted patients who might be enrolled in
successful programmes. In fact, most dually diagnosed addicts are excluded from treatment entrance, unless entrance is mediated through special channels (e.g. when it is preceded by coercion under psychiatric treatment). In this case, too, dually diagnosed addicts are likely to enter specific treatment programmes quite late in their personal history. Against those who argue that psychiatrically ill addicts would hardly gain any benefit from specific treatment, we have shown that they are the category that benefits most from specific full-dose agonist maintenance. In fact, the PISA-SIA Group dually diagnosed addicts appear to be more likely to have a positive outcome (i.e. psychosocial restoration and stable abstinence) than uncomplicated peers. In reality, that difference is not accounted for a higher rate of treatment accomplishment by dually diagnosed addicts, but by a greater likelihood of staying in treatment. Treatment requirements appear to differ between the two groups as regards the level of the stabilization dosage (which is somewhat higher for dually diagnosed addicts) and the time taken to reach a condition of stable abstinence (which is somewhat longer for dually diagnosed addicts). In conclusion, as far as those requirements are automatically fulfilled within an illness-centred programme (supposing there are no limits to dosage or dosage maintenance), the applicability of an effective treatment as agonist maintenance can be widened to comprise traditionally treatment-resistant subjects. In line with previous clinical observations, it can be hypothesized that methadone’s incisive action upon psychopathology have a role within a harm reduction approach, in bringing the addict closer to the opportunity of a high-threshold intervention. When instruments for intervention such as the controlled administration of agonists within a street-approach are scientifically handled by harm-reduction practitioners, this may enhance the threshold tolerance of street-junkies, so making high-threshold, illness-centred interventions feasible. However, even if a subpopulation of heroin addicts must stay outside any possibly effective treatment, the use of a direct psycho-active instrument such as methadone may improve their compliance with low-threshold, harm-reduction campaigns. This may be especially true for dually diagnosed patients, whose psychopathology-related harmfulness to themselves and others would be specifically buffered by methadone administration, at sub-therapeutic levels, even if in the absence of a heroin-free condition.

Conclusion: specific harm reduction in the treatment of heroin addiction

Up to now, harm reduction and specific treatments have been based on two distinct philosophies of intervention, springing from political or cultural attitudes. Currently, harm reduction and specific treatment tend to divide addicts into two categories: highly impaired ones, who can hardly be targeted, in terms of the goal of curtailing personal and social risks; and addicts fitting high-threshold approaches, who can achieve a satisfactory and stable degree of control over their disease. In a similar way, harm reduction and specific treatment tend to resort to different instruments, so that they differ both in treatment tactics and strategy. We do not deny the need for harm reduction: when high-threshold treatments take precedence over harm reduction, the most severely ill
addicts are destined to meet their death while outside any form of care, which is not in line with the spirit of a civilized country. Moreover, whole categories of addicts are left outside any treatment perspective, despite being those supposed to benefit most from a correctly structured programme (i.e. dual-diagnosed addicts). On the other hand, when harm reduction is dominant within a clinical setting, no actual therapy for addiction is possible, on personal and on social grounds. Thus, although addicts may not die of drug-related causes, thanks to successful harm reduction targeting, they will die as heroin addicts. It is, in any case, reasonable to work for the recognition of harm reduction as a level of intervention sharing the same strategy as specific approaches, and therefore using the same instruments. As this is the authentic the role of harm reduction, an unbroken transition from harm reduction to high threshold settings becomes possible. In other words, a continuous, low-threshold intervention may gradually increase patients’ adaptability and flexibility, so making high threshold facilities a feasible option.

References


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The war between 1991 and 1995, brought destruction, migrations and victims to Croatia, but it also brought a heroin addiction epidemic. The supply of methadone was undermined by war-related crimes and demand was paralysed by confusion about the options that were available. Croatia did have a number of experienced specialists in the field of addiction, and, fortunately, their ideas were accepted and promoted. Methadone was introduced through a “slightly open door”, but no official announcements were made. The first patients were admitted to MT in 1991. Of an estimated 15,000 heroin addicts, about 7,000 were given some kind of treatment, including 3,000 in MT, and about 2,000 in MMT. Methadone policy specifics are: 1. Health insurance coverage that includes MT for virtually all addicts. 2. Centres for outpatient treatment in all major cities. 3. Completely decentralized prescription and dispensing of methadone through GP offices. Despite the lack of strict rules, or maybe just because of that, MT in Croatia is well established and is generally viewed favourably. The obstacles encountered so far have never reached a level that might jeopardize the fundamentals of the programme.

Key words: Methadone Treatment - Problems and obstacles - Policy Initiatives

Croatia is one of the youngest European states, but one of the oldest European countries; it had to wait over nine centuries to win back the independence. Regrettably, reawakening after a long dream was not at all pleasant. As typically happens in history, war was the price for freedom. In this case war lasted from 1991 to 1995, bringing not only destruction, migrations and victims, but also a heroin addiction epidemic. Croatia lies on the famous “Balkans Route” of heroin supply for west Europe, but until the early 1990s heroin addiction was sporadic or local, rather than a national problem.

The government found some kind of answer for most of the challenges it faced, but it had no answer for a heroin epidemic. The supply of methadone was undermined by
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the war situation and the war-related crime, but at least it was clear what should be done. Conversely, the fall in demand was something about which nobody knew where to start and what to do.

Methadone was available as one of the options, but for the government it was extremely controversial, because it was considered to be highly suspicious by the ‘moral authorities’.

Finding itself holding a ‘hot potato’ and not knowing what to do, the government decided to do anything. They left the problem to medical specialists and experts, without making any announcements or setting up any regulation!

Fortunately that was the best solution for Croatia.

Introduction of methadone in treating addicts, 1991

In Croatia methadone for the treatment of addicts was introduced through the “slightly open door”.

As an opioid analgetic for sever pain, mostly in cases of cancer, it has been widely prescribed for more than 30 years, but at first the idea of using opioids as a medicine for opioid addictions, seemed unimaginable. Methadone was often misused by heroin users as a “substitute”, which raised the question “How can a medicine which is abused and is considered illegal be used as a therapy against addiction?” Over a long period heroin addiction was not a major public health problem, so people did not even have to think about it. But the problem grew, and the need for new treatment options became irresistible. The first to understand the new situation and the new position of methadone was Dr. Sakoman, the head of the Department for Drug Abuse at the Sestre Milosrdnice University Hospital, Zagreb. Founded in 1970, this department was the first of its kind in former Yugoslavia. He used methadone first for inpatient detoxification. But inpatient use has never been called into question. It was outpatient use that was questionable! In 1991 the first inpatients were discharged, and referred back to their own doctors for the completion of methadone detoxification. Without exception, it was a success! The door was opened and methadone was on the scene!

How was it possible for such a controversial therapy to be introduced without any official approval?

Without considering the sociological setting, which is important in itself, some of the following factors may provide part of the answer:

• As methadone treatment was not officially approved, there was no reason to start a debate about it in the social, political or medical communities; that meant there was no significant opposition.
• In the early 1990s, GPs, who took on most of the responsibility for initiating MT, were still on a state salary and were practically obliged to accept all the recommendations that reached them from hospitals within the health system.
• Methadone treatment came in as part of detoxification programmes, and was seen as “temporary therapy”. Initially the term “substitution” and “maintenance” were
not used.

- The personal influence of Dr. Sakoman in introducing methadone and promoting a humane, public health approach for heroin addicts was decisive. Most importantly, addiction was treated as a medical problem, so that “addiction is like any other disease” and “methadone is like any other medicine”.

  As with any other disease, therefore, there were no printed programmes with strict rules, only the following principles that have been left intact so far:

  - Methadone should be offered and provided to anyone who needs it.
  - No selection criteria for entering the programme. Age, period of addiction, and history of failed treatment attempts should be part of the input for inclusion or assessment and never stand as criteria for exclusion (i.e. age under 18 is generally not recommended for MT, but under certain conditions is acceptable).

  - Practically no discharge policy. Illegal opioid consumption is not a reason for discharge. Discharge can happen as an “individual event”, not as a consequence of the policy.

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**Figure 1.** Opioid patients treated for the first time (1970-2001) in the Centre for Addiction at the Seste Milosrdnice University Hospital, Zagreb, Croatia

With permission from: S. Sakoman, "Drustvo bez droge (2002), Ivo Pilar Istitut, Zagreb

Once started, M T quickly brought a dramatic change in the treatment of addicts. Discussions and arguments started, but nobody could “push the genie back in the bottle”.

In a couple of months the first few hundreds of addicts entered the programme; by the end of 1995, over 1500 had been treated. There were no significant problems in prescribing and dispensing methadone, but it became evident that centralized methadone induction was insufficient and needed to be changed. Finally, in 1996 the Croatian Parliament approved the “National strategy for drug abuse control”, the first document to be issued on the prevention and treatment of addiction, and on limiting the supply of illegal drugs. The “National Strategy” was not a law, and did not oblige anyone, but it was the first document to indicate government support for programmes that had already been operative for over 5 years!

On the topic of treatment, the “National Strategy”, in practice, described programmes that were already in place, and emphasized the recognized principles of treatment. The crucial innovation was the idea of establishing “Centres for outpatient treatment” in all counties and bigger towns, with the aim of helping to set up specialized units and enhancing the availability of treatment.

The early phase: 1996-2001

After 1996, Centres for Outpatient Treatment were established in all the areas facing drug problems; so far there have been 15 of these.

Again, it was not the central administration that decided on this important step, but local communities, who took the initiative and provided the funding. Due to lengthy political confrontations, it took a full five years after the publication of the “National Strategy” for the “Law on Drug Abuse” to be passed, and that only happened after many compromises and inadequate solutions (6).

Current situation and comments

Nowadays methadone treatment in Croatia is well established, and, despite all the problems, the programme is receiving widespread approval.

The three cornerstones of the programme are:

1. Network of Centres for outpatient treatment

Centres are the focal points for outpatient treatment. On the basis of a clinical assessment they may administer methadone, decide starting doses, type of treatment regimen, suggest supplementary medication, provide psychosocial counselling, do evaluation and collect epidemiological data.

Centres employ interdisciplinary teams comprising practitioners, psychologists, social workers and medical nurses.
Psychiatrists are usually responsible for Centres, but other specialists or general practitioners may be put in charge after receiving additional, mostly informal education. Non-psychiatric directors seem to do their work as successfully as psychiatrists and are equally acceptable to patients and colleagues. Apart from the fundamental principles already stressed, there are other factors influencing the efficacy of Centres:

- Accessibility. Centres have been set up in all cities that face an addiction problem, usually at convenient locations.
- There is no waiting lists for entry.
- All services, including psychosocial counselling, are free of charge.

2. General practitioners prescribing and dispensing methadone

There are no inpatient methadone centres in Croatia. Methadone treatment is, therefore, decentralized thanks to GPs, who have taken on the hard task of managing MT. The philosophy of considering methadone to be “like any other medicine” could only have been made effective “on the solders” of GPs. After an assessment at a Centre, an addict is referred to his or her own doctor, who then continues to prescribe methadone, and not only prescribes it, but dispenses it!

A doctor or a nurse has to get methadone from a pharmacy and provides it for consumption, usually in the form of daily supervised consumption in the office. Moreover, for take-home doses a nurse has to prepare a solution, as no methadone syrup is obtainable in Croatia: that means methadone tablets must be crushed and mixed with juice (which usually has to be procured by the doctor!). An intense, well-distributed network of GP offices makes methadone available “in every village”. It is estimated that out of 2400 GPs in Croatia more than 1000 have patients on MT. A clear majority of doctors are favourable to MT, and disagreements are rare.

3. Good health insurance coverage

The services provided at Centres are funded at state level, and are completely free of charge; methadone dispensing is available to virtually any addict who has direct access to health insurance.

Even if not initially insured (but most of them are), heavy addicts will be able to obtain full insurance because of their addiction.

These safeguards have had a strong impact on access to, and retention in, the programme.

Problems and obstacles

MT has become an indispensable achievement of the Croatian health and social system.

The obstacles encountered so far have been insignificant, but they are growing and are beginning to threaten the basic principles of the programme.

- “Traditional” drug-free orientation. Even when it is unreasonable, there is an
insistent demand for “less methadone”; it comes from providers, but also from families and addicts themselves! Addicts dislike the term “maintenance”, and prefer to express the thought by saying that they are on a “very long detoxification”. That fact influences many MMT outcomes.

- **Lack of rules for methadone treatment.** When MT was first introduced, the lack of rules played a historic role, but there is now a growing need, not for rigid regulation, but simply for a description of procedures and guidelines. The lack of rules is one of the reasons for dose diversion and the making of errors; incidents like these are misused in the media to undermine treatment programmes.

- **Payments to GPs participating in the programme.** The health authorities reject the idea of making extra payments to GPs for their hard work in prescribing and administering methadone, taking the idea of addiction being “just another disease” to an absurd extreme. GPs are paid on the basis of the number of their patients, receiving 134 kunas per year (about 17 euros) per person per year. This includes complete primary health services and, in case of an addict, daily supervision of his or her intake of methadone. In 2001 the Minister of Health refused a proposal to authorize the payment of about 25,000 euros per year to all GPs in Croatia who have patients on MMT.

- **Claims for centralization have their advocates.** The only argument in favour of the centralization of dispensing is that doses of methadone may be diverted. This idea springs from the intention to institutionalize PT by setting up a bureaucracy under political control.

**Facts an indicators**

To contextualize the situation in Croatia, table 1 provides some basic information. Of 4,000 registered addicts not on methadone, about 800 live in therapeutic communities, 500 in prison, and over 1,000 are in a “drug free programme” – an expression referring to patients with a good contact with Centres and good social adjustment; most of these patients are employed or studying, and are abstinent or only rarely consume opioids (3).

- **HIV infection and AIDS.** Croatia has a low overall HIV infection rate, estimated

<table>
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<th>Table 1. Drug (Heroin) Addiction situation in Croatia</th>
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<td>Population</td>
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<td>Estimated Heroin Addicts</td>
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at 0.0015%. Only 171 AIDS cases have been recorded, from the start of the epidemic until 2000. The HIV infection rate among heroin addicts is 0.8 - 0.9% (2-4). It is highly likely that these good figures are partly due to the availability of methadone.

- **Hepatitis rate.** About 50% of addicts are HBV or HCV positive (3).
- **Average dose** for those in MMT is estimated as 65 mg (3).
- **Deaths from overdose** in the last couple of years have been between 50-60 annually (4).
- **Diversion of methadone.** It is hard to estimate the proportion of methadone being diverted, but the price of methadone on the black market, which is 10 times higher than it is in pharmacies suggests that it is not substantial – 30 euros for a 100 mg dose on the street and 3 euros in pharmacies. The fact that at most 10% of overdose deaths are attributed to methadone, strengthens that suggestion.
- **Retention rate** is estimated to be over 80%. Of 119 addicts in treatment at the Porec Centre, 99 (83%), are still in the programme (5).

**Conclusion**

Despite the lack of strict rules, or maybe just because of that, methadone treatment in Croatia is well established and is generally viewed favourably. So far the obstacles to its use have not been significant and have never reached a level high enough to jeopardize the fundaments of the programme.

The concerns expressed about the phenomenon of diversion seem to be exaggerated, while the claims put forward for better control and greater centralization are another name for a ‘high threshold’ policy, which could lead to poor availability and rising political control over what is a ‘normal’ public health problem.

**References**

**VI EUROPAD FORUM during AATOD Conference**

**PROGRAM**

**Renaissance Hotel, Washington, DC, USA**

**Sunday, April 13, 2002**

**Chairmen:** Icro Maremmani (Italy) and Marc Reisinger (Belgium)

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<td>Michael Arieli (Israel)</td>
<td>Prescription drug abuse: The impact of war and economic stress on normative and non normative populations in Israel</td>
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<td>Jean Jacques Deglon (Switzerland)</td>
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<td>Roberto Mollica, Paola Carleo, and Riccardo C. Gatti (Italy)</td>
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<td>Lubomir Okruhlica, Ferdinand Devinsky, Marian Hrabovsky, Jindra Valentova, Danica Klemova, Zuzana Vickova (Slovak Republic)</td>
<td>Different correlation of methadone doses and plasma concentrations in two groups with different take-home regiments</td>
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<td>4:20 p.m.</td>
<td>Pier Paolo Pani, Emanuela Trogu, Gianfranco Carboni, Patrizia Palla, Anna Loi (Italy)</td>
<td>Psychiatric severity and treatment response in methadone maintenance treatment program: new evidence</td>
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<td>4:40 p.m.</td>
<td>Marc Shinderman (USA) and Roberto Nardini (Italy)</td>
<td>When enough is not enough. Using high dosages of methadone</td>
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The renaissance of methadone treatment in America

Mark W. Parrino

Summary

The renaissance, or revitalization, of methadone treatment services in America is driven by new accreditation standards, as promulgated by the Centre for Substance Abuse treatment, the primary oversight federal agency for methadone treatment services in the United States. These new accreditation standards were implemented during May, 2001, replacing the previous Food & Drug Administration regulations, which had been in force since 1974. The accreditation standards emerged from a number of critical reports concerning the quality of methadone treatment services in America, beginning with the General Accounting Office’s review, which was published in March of 1990, titled “Methadone Maintenance - Some Treatment Programs Are Not Effective; Greater Federal Oversight

Key words: Methadone Treatment - Accreditation standards - Quality of care

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Needed” [6].

In the judgment of our Association, while accreditation will not be a fiscally or organizationally neutral method of spearheading the revitalization of methadone treatment, it represents an extremely viable method of improving quality of health care in these facilities. We expect to learn a great deal about the quality of health care system as all 950 methadone treatment programmes experience accreditation surveys during the course of the next 2-3 years. We also know that approximately 205,000 patients are enrolled in these methadone treatment programmes according to the Centre for Substance Abuse Treatment.

While many may argue the merits of implementing this nationwide system of accreditation oversight for methadone treatment, there is a clear need to improve clinical services throughout treatment programmes in America as we develop partnerships with the criminal justice system and mainstream medical care. Methadone treatment programmes could inadvertently short-circuit such new opportunities for working with other affiliated agencies ad organizations if methadone treatment services are not of good quality. While accreditation is not expected to be the answer to all critical problems in methadone treatment, it will provide the ability to enhance quality of care as patients get access to a more consistent level of services.

Our Association recently changed its name to the American Association for the Treatment of Opioid Dependence because our Board of Directors felt that it would broaden our mission. It was also felt that it would be far better to name our Association after the disease being treated as opposed to a medication that has been used historically to treat the illness. We also implemented a Five-Year Plan, building on the accreditation oversight mechanism, setting forth a series of objectives to expand access to methadone treatment services in America. We have seen the increasing emergence and importance of Drug Courts throughout our culture and have decided to educate Drug Court practitioners about the long-term value of methadone, ORLAMM and other medications as they come into use (Buprenorphine) [8].

It is equally important to change existing federal agency policies in America that run counter to all known research findings. Illustratively, the Department of Transportation and the Department of Justice have policies that are harmful to methadone-maintained patients. At present, the Department of Transportation prohibits methadone-maintained patients from using commercial driving licenses for interstate commerce. In addition, the Department of Justice also promulgate anti-methadone policies through its “Guide to Judiciary Policies and Procedures/Probation Manual”, stating that “Methadone is a highly addictive morphine substitute. While widely used in the treatment of heroin addiction, methadone itself produces many of the same negative effects of heroin”. While these statements do not reflect scientific reality or clinical practices, they are guiding a number of negative decisions, which affect the lives of methadone patients throughout the country.

The plan also builds on the only methadone treatment programme in a prison system (Rikers Island - New York City). The intervention is called “Key Extended entry
Program” (KEEP) and has been a part of the Rikers Island health Services system since 1987. The programme was initially developed through a cooperative relationship between the New York City Department of Corrections and the New York State Division of Substance Abuse Services. This prison based methadone treatment programme treated 4,431 inmates with methadone in 1998. All inmates had been diagnosed as being opiate dependent by medical staff and charged with either a misdemeanour or a low-grade felony, serving a brief sentence in order to qualify for access to the treatment programme. Almost 80% of all inmates patients reported to their assigned methadone treatment programme for continued substance abuse treatment following their release from jail, dramatically cutting recidivism [9].

It makes sense to expand access to this successful program in prisons and jails throughout the United States since it represents an enormous cost saving from the typical cost in incarceration ($18,500.00 per year) as compared to the average cost of methadone treatment services in America ($4,700.00 per year).

It is important to understand some of the demands that are driving the need for improved quality care and an expansion in treatment access.

The SAMHSA 1998 National Household Survey on Drug Abuse showed that there were 81,000 new first-time heroin users in the United States in 1997. The survey also indicated that the average age of first heroin use dropped precipitously from 26.4 years of age in 1990 to 17.6 years of age in 1997. This represents an extremely dramatic decline in the age of first heroin use, creating an additional demand on young, opiate-dependent people attempting to gain access to a limited number of methadone treatment slots throughout the country. The “Monitoring the Future” study, which was part of the White House ONDCP report in 2000, also indicated a significant prevalence of heroin use among high school students. Approximately 1.5% of 10th-grade students used heroin during their high school years in 1998. DEA data also showed consistent purity of heroin at the retail level during the years 1995-1998, while the average price for heroin per gram decreased both at the retail and wholesale level during the same reporting period. FBI uniform crime reports from 1995-1998 also showed an increase in drug-related department mentions, also showed significant increases for the reporting periods of 1995-1997 in a number of cities throughout the United States, notably New York, Newark, Chicago, Detroit, San Francisco, Seattle and Baltimore. The policy argument for methadone maintenance treatment has generally been driven by comparative costs for the untreated heroin users ($45,000.00 per year) as opposed to incarcerating the heroin users ($18,500.00 per year) versus methadone maintenance treatment ($4,700.00 per year) [10].

Dr. John Ball indicated in his research, a NIDA-funded study published in 1991, the dramatic difference in pre-treatment crime versus crime committed as the patient remains in methadone treatment, with a dramatic decrease of 80% [2].

An additional support for methadone treatment has been the decrease of HIV-seropositivity among established methadone maintained patients compared to new admissions [1; 3- 5].
The Ball & Ross study, as referenced above, also demonstrated that 82% of methadone-maintained patients relapsed into their pre-treatment heroin use within 12 months of ending methadone treatment. This figure included both voluntary and involuntary discharges from treatment.

The Association’s Five-Year Plan will increase access to a continuum of treatment services, including medical maintenance treatment where stable methadone-maintained patients, who have met established criteria, are referred from the hub methadone treatment programme to off-site private physician practice settings. This model will create a linkage between the existing methadone treatment system in the United States and a series of qualified physicians who have an interest in working with the stabilized patient. The Association’s current criteria establish a 36-month period of stability prior to making this referral. This trend represents the successful model that has been used in the Beth Israel Medical Centre medical maintenance programme, which has been in existence for more than 15 years [7].

Our Association will continue to educate allied professional groups about the value of methadone treatment as we work to mainstream with physicians in private medical practice settings to incorporate medical maintenance treatment options in addition to working with federal agencies and parts of the criminal justice system in order to provide steady access to treatment for people who benefit from methadone maintenance.

The renaissance or revitalization of methadone treatment in America will take years to develop and a reasonable starting point is the accreditation oversight system. Another important element of our plan is to continue to work cooperatively with our colleagues throughout the world, specially with EUROPAD, as we form a worldwide federation of methadone treatment providers. Without any question, we are facing great challenges but also great opportunities.

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programs are not effective; greater federal oversight needed, GAO/HRD, New York, NY.


Methadone and commonplaces

Patrizia Gioè, Brigida Rosa, Marina Papa, Maria Troia, Filippo Triolo

Summary

Research developments in methadone research point to the need to give adequate doses in maintenance programmes for the treatment of opiate dependence. This suggestion often clashes with the long-standing prejudices of users, who are not fully compliant with long-term substitution programmes; this makes it difficult to fully implement the correct treatment. Our service has therefore tested a different intervention methodology, in order to: 1) favour treatment retention; 2) improve the quality of the treatment itself. Small groups of users under substitution treatment were formed; they met for counselling in a group setting. This form of open discussion allowed: 1) health workers to provide correct information about methadone; 2) patients to learn more about drug addiction and its possible treatments, by following a new route to self-knowledge and taking part in interactive confrontation; 3) both groups (health workers and users) the opportunity to have a more genuine and confidential relationship. In order to make available to those outside the experimental group the subject of this experience, a comic strip directed to all the other users of the service was prepared. One year after the conclusion of this experimental technique, all the users who had been involved in it were still compliant with treatment, in line with the initial therapeutical project, and some of them have entered the detoxification phase.

Key words: Methadone Maintenance - Counseling - Psychotherapy - Follow-up

Introduction

In our view, counselling should be considered an essential component of effective methadone treatment.

Procedures that aim to train patients in how to take medicines in the correct way have, for some time now, been included in psychiatric psycho-educational programmes, where they have proved to be successful in raising levels of treatment compliance,
Heroin Addiction and Related Clinical Problems

reducing hospitalization and facilitating social rehabilitation.

A variety of reasons justify their use with drug addicts. These patients often have no clear perception of their problem or of how to deal with it; no universally accepted references exist on drug addiction phenomena, and prejudices about therapies persist.

The present definition of drug addiction as a chronic and recurrent illness often has difficulty in winning acceptance. Drug addiction is still often interpreted as a habit that must be fought with willpower and the support of others - family, friends and health workers.

Things are even more complicated when methadone therapy is taken into consideration. Indications given by health workers on the correct way of carrying out methadone treatment often conflict with years of experience by drug addicts as well as with commonplaces constantly strengthened by groups of same-age people: “Methadone is a drug”; “60 mg is too much; I will never get out of it...”;”It cannot help me - I am not an addict”.

Those who are on methadone are often seen as serious drug addicts, or as being weak, and so unable to make it on their own. In the patient’s imaginary those on therapy with methadone are “dirty”, in contrast with those who are drug free or on treatment with Naltrexone, which is considered to be “clean”.

In many cases, therefore, at least at the beginning of our study, the patient came to methadone therapy urged by the need to get over withdrawal symptoms quickly, while maintaining the prospect of reducing, and then suspending, the intake of methadone as soon as possible.

Over the years, these opinions have seemed to become axioms, often shared by drug addicts, their families and public opinion. For patients, methadone treatment often becomes an expedient, and is unappreciated as therapy; it is felt to be a result of their failure, and there is little confidence in its success. All this affects the therapeutic process negatively.

For all these reasons we have come to consider the use of counselling as a fundamental instrument in improving pharmaceutical treatment and, at the same time, in initiating cultural changes pertinent to the role of substitute therapy.

We have assumed that it is possible to intervene on the commonplaces circulating about methadone by using a place visited in common where treatment can be discussed on a group basis, starting with the question of prejudice.

Aims

For this purpose we have organized discussion groups on methadone therapy so as to favour confrontation between patients. Our aim has been to:

a) improve relational modes;

b) allow the expression of prejudices on methadone therapy, with criticism developing through confrontation with others;

c) give correct information on methadone substitute therapy;
d) favour the circulation of new ideas;
e) strengthen compliance with treatment to improve its quality;
f) optimize health service resources by involving a minimum number of patients in each group.

Methods

Two groups of volunteer patients, selected from among those who had been on methadone treatment for at least a month, were formed.

These groups, of 4 and 5 people (comprising a total of 7 men and 2 women), met once a week for about 6 months in the presence of 1 or 2 health workers who had adopted the group counselling technique. A psychiatrist, a pedagogist and a social worker also joined each group. Each meeting centred on a specific theme. During each session, lasting an hour, a discussion was opened on a specific controversial aspect of methadone therapy, such as:

“Is drug addiction an illness?”
“Is methadone a drug?”
“How does methadone work?”
“What is the effective dosage?”
“For how long should methadone be taken?”

During meetings, ample scope was left for patients to talk about their own experiences. This became a starting point for information to be given and for inappropriate behaviours to be corrected.

Results

Patients' personal experiences

Even though the meetings had an informational-educational objective, it was natural that, within each group, significant relational dynamics yielded a structure that had an emotional aspect. In meeting after meeting, each participant took the opportunity to talk about his/her personal experience, and go into difficult, intimate matters, which, in many cases, had never been faced during individual sessions.

During meetings we had the opportunity to observe that a real chance to acquire new knowledge usually came when patients’ personal experiences confirmed themes suggested by health workers. Patients, in fact, naturally gave more credence to the experiences recounted by people of the same age-group than to the “scientific” words used by health workers, even if the former were strengthened by the latter.

It was therefore possible for patients to become aware of aspects of their addiction that they had never faced before, becoming able to observe, gradually and critically, some of the preconceived ideas that had built up over the years. Particular attention was given, during sessions, to two elements of methadone treatment that, at least in terms of
our experience, had proven to be problematic:
1) dosage of medicine;
2) treatment duration.

During meetings, the discussions that began on various themes proved to be useful in explaining the importance of an individual adjustment of dosage and of its maintenance for a suitable period so that the effectiveness of treatment would not be compromised.

The opportunity for patients to know and understand the reasons for some therapeutic prescriptions, which are not always readily accepted, favoured compliance with treatment besides highlighting the importance of following personalized therapeutic programmes. Moreover, confrontation made it possible to discredit a series of prejudices and commonplaces that often interfere with patients’ compliance and with the quality of therapy. Lastly, the desire to give continuity to a new and significant experience brought the group to seek a helpful tool that would allow them to share what came out of discussions, with other health service patients.

This led to the idea of publishing an informative pamphlet on methadone treatment, by using comic-strip language, which was considered stimulating and capable of arousing curiosity.

The exchange of views did, in fact, make it possible to openly explore themes such as relationships between people in the same age-group, the struggle to survive, the concreteness of everyday problems, and relationships with outsiders and family members.

Once all this became part of conversation, a specially talented patient with a sensitive nature and great artistic ability took it and transformed it into images, using the leading idea that had emerged during the discussion as a theme for the comic strip: an inspiration resulting from the encounter between the groups’ suggestions and emotions, or between rational and cognitive aspects, as well as from the personal contribution of the patient who volunteered to draw the strips.

The patient, in fact, sketched a good number of illustrations, caricatures and scenes, only some of which were used for the publication.

Besides allowing a predominance of graphic over verbal elements, the style and setting of the images immediately communicated the path followed by the group, and gave the thought contents an effective medium.

The comic strip narrates the most noteworthy moments in a day in the life of a drug addict who meets an old friend who is on methadone, and therefore has a chance to think and receive new information about the correct consumption of the medicine. The title, “Facts of daily life”, playing on two levels of meaning, was chosen for the story. The patients found it natural to use their dialect language to complement the graphic side. The commitment to make the comic strips as straightforward and simple as possible inevitably led to a sacrifice of some of the striking richness of the original graphic production.

From the elements that had been discarded, a poster took shape, which gathered
analogically, and with great emotional force, the reflections on their experience made by patients in commenting on their condition and identity. It is a collage made by health workers, who used the preparatory graphic material that had been sketched by the illustrator patient and that was therefore rich in useful hints.

The existential themes around which the beliefs, habits and repetitions of patients under treatment rotate can be traced in this poster.

The groups met once a week for six months, starting in February and continuing till July 2000.

A year after the conclusion of the experiment, 8 of the patients involved in the project (there were 9 in all) are still on substitutive therapy and are showing better compliance. In two cases minor relapses took place, during treatment. Six subjects have been drug-free now for over a year; 5 of them are in a detoxification phase.

An informative brochure was published for patients and their families.

Conclusions

Now, almost a year after the experiment ended, we have the feeling that something has changed in the culture of the health service and in the “beliefs” held about methadone by patients.

Those who took part in the groups now relate differently to other patients and to their own families with respect to therapy.

In the waiting room and infirmary, and in the other meeting places available to patients, new ideas circulate that positively influence their behaviours and compliance.

We have, for example, noticed a reduction in the persistent requests once made to decrease methadone treatments and a lower resistance to the use of dosages that were once commonly believed to be too high.

Our greatest effort, at the moment, is dedicated to avoiding the premature conclusion of treatments. To achieve this, we intend to continue using the counselling technique for our future work, gradually involving a rising number of patients that may act as a resonance chamber for other people who will be applying to the health service for help.

References


Methadone maintenance and HIV infection

Matteo Pacini\textsuperscript{1,3} and Icro Maremmani\textsuperscript{1,2,3}

Summary
Methadone therapy has been widely shown to be the most effective treatment for opioid addiction. The increase in its use was promptly followed by a dwindling rate in the spread of HIV among heroin addicts. Clear benefits emerged, not only among directly treated patients, but also among non-addicts sharing the same environment. The positive impact of methadone upon addictive behaviours can be read mainly as a reduction in the likelihood of seroconversion. Retention in treatment is the most reliable predictor of a lower probability of seroconversion that will be maintained through time. The administration of methadone, even in cases for which stabilization has not been achieved, or for subjects who do not comply with methadone maintenance programmes, is still effective in a harm reduction perspective, in so far as it keeps infective risk lower than expected. In dually diagnosed patients, methadone, thanks to its psychopharmacological properties, has an immediately beneficial effect both on addiction-related behavioural disorders, and on further dysphoria and impulsiveness related to the adjunctive mental illness. Increasing numbers of heroin addicts should initiate methadone treatment, in order to minimize the likelihood of HIV-infection during the course of addictive practices. Moreover, stabilization, rather than a drug-free condition, should be regarded as the optimum therapeutic achievement. The advantage of this view appears evident when it is considered that, besides preventing relapses into heroin use, which could be checked by the re-initiation of a programme, stabilization forestalls frequent consequences of heroin use, such as HIV and HCV infection; these two conditions do not, at the moment, respond to any widely effective therapy.

Keywords: HIV - Seroconversion - Methadone Maintenance - Addiction - Dual Diagnosis - Harm Reduction

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Introduction

Intravenous drug users make up the largest group among subjects with AIDS. By 1992 the percentage of AIDS-affected individuals who were drug injectors has risen to 40% [37]. During recent years, drug addicts have been the exposed category that has experienced the steepest increase in the incidence of HIV infection [37]. In Europe, where the rates of drug-addiction are almost the same in different countries, the prevalence of HIV-seropositivity varies from 3 to 315 per million inhabitants, which is a strikingly wide range. Moreover, HIV-infection has increased by different rates in different countries, so that the global European increase in the HIV infection rate is mostly due to the reported increases in three countries (Italy, France and Spain) [38]. Data show that the variability in the prevalence and incidence of AIDS is not proportional to the number of drug addicts in each country, but is inversely correlated with the percentage of heroin addicts who are currently under methadone treatment. A greater availability of methadone programmes is positively correlated with a lower prevalence of AIDS in the general population. Enrolment in methadone maintenance programmes appears to have worked, through the epidemic years of HIV infection, as a barrier against the spread of HIV infection in a highly exposed category – that of injecting drug-addicts.

Psychopathological core of addiction and probability of seroconversion

It is well known that an addict’s behaviour involves exposure to the risk of infective events, by a sexual, or injecting mode. Some specific factors are there to link ordinary addictive behaviours with these two modes of contagion: on one hand, the self-injection of substances; on the other, the incidence of unsafe sex linked with providing oneself with daily supplies of heroin. These latter include trading sex for drugs or money, and preferential or changing sexual partnerships with other drug injectors. More exactly, the infective jeopardy of drug-injectors does not only arise from the frequency of injections: in other words, the lower levels of infective jeopardy of drug injectors who have not developed any addictive behaviour does not depend only on their injecting less often, but also on the absence of specific behavioural patterns which characterize injecting sessions. Likewise, the infective risks linked with unsafe sexual practices are not wholly attributable to the patient's need to obtain daily doses of highly expensive substances. In fact, it is loss of control due to addiction that underlies risk behaviours, so that drug-related prostitution bears a higher risk of infective incidents than generic sex-trading.

By definition, addiction means a loss of control over substance-seeking, substance-taking behaviours. Addicts experience an affective state of craving which is the precursor to drug-seeking behaviours, and is marked by urgency and an intense drive, so that the threshold for drug-seeking and drug-taking acting-outs is lowered. The impulsiveness and urgency which mark out an addict’s affect and behaviour, respectively, lead subjects to bear the brunt of personal jeopardy in so far as it is the price to pay for the substance’s availability. Moreover, even when the substance is available, the
craving may be so urgent as to make addicts careless about safety rules, infective prophylaxis, and even the kind of person they exchange needles with. Similarly, addict’s tendency to choose their sexual partners among those who are most likely to supply them with the substance, implies that partnerships run a high risk of HIV transmission. Overall, it is addiction itself, not just substance use, that makes subjects incapable of taking precautions over their own health, because substance availability is their overwhelming priority. In other words, addictive disease makes those who suffer from it unable to choose the safest or most appropriate conditions for injecting, or wait for safer conditions to arise. Nor are they able to reject the opportunity to share injecting equipment with probably unclean individuals, even when a safer solution is almost at hand.

**Non-opiate abuse and likelihood of seroconversion**

Addictive cocaine use is associated with risk behaviours such as unsafe sex and changing partners [7; 19]. In methadone-maintained populations, intravenous cocaine use is a risk factor for seroconversion [7; 9; 19; 40; 46], and the risk of seroconversion increases with the frequency of cocaine injection. Also, the documented weight of ethnicity in the risk of seroconversion is related to the different rates of injecting users in populations of addicts belonging to different races [9]. In any case, it has been reported that, in multiethnic populations of intravenous cocaine addicts, the probability of seroconversion is greatest in Afro-American injectors [31]. As a mode of drug use, injecting is not enough by itself to account for all the risk of infection run by addicts; crack cocaine use, for instance, is associated with a probability of seroconversion as high as that found with intravenous cocaine use. In fact, crack addicts display an enhanced sexual activity [5; 12; 17] which is greater than that of heroin addicts [12]. On one hand, this is consistent with cocaine’s psycho-active effects compared with those of heroin (”active” vs. “passive” euphoria); on the other, as far as unsafe sex-trading practices are concerned, it can be hypothesized that a greater lack of control is experienced, consistently with the cocaine's profile as the most intensely addictive substance known, and as capable of inducing paroxystic craving and behavioural conditioning.

Methadone treatment is effective in reducing risk behaviours in heroin addicts, even when cocaine abuse is concurrent [28]. Even so, cocaine abuse remains a negative predictor of outcome both in methadone [40] and buprenorphine programmes [39]. For example, the fall in retention rates among heroin addicts enrolled in methadone programmes, located in New York between 1981 and 1988, was concomitant with the rise in the rate of cocaine use in the same areas [40]. Cocaine abuse during methadone treatment should continue to be viewed as a factor in behavioural instability: in fact, during exposure to opiate agonist buffers, and to the psychotoxic, and possibly somatic effects of cocaine intoxication, neither methadone nor buprenorphine has shown any significant effect on cocaine-taking behaviour.

Benzodiazepine use is a risk factor for infectious diseases, too [14]. It should be
borne in mind that this phenomenon may have various different implications: while a few heroin addicts suffer from true benzodiazepine addiction, becoming autonomous and unresponsive to methadone treatment, the vast majority of Bdz abuse is due to undermedication by opiate agonists; in these cases a quick resolution can be achieved by increasing methadone doses.

**Methadone as a means of prevention of HIV seroconversion**

The enrolment of heroin addicts in methadone maintenance treatment programmes has proved to be an effective measure in preventing HIV infection [3; 4; 16; 42; 44]. Among heroin addicts who began treatment in or before 1981, AIDS-related deaths have been less frequent than among peers enrolled after 1981[40]. During the years of the HIV epidemic, AIDS becomes the first cause of death in addicts under treatment, whereas other common drug-related fatalities were averted due to the successful control of addictive behaviours [1]. Therefore, methadone maintenance has helped to protect subjects who were HIV-negative at treatment entrance, throughout the HIV epidemic. Further support for this viewpoint comes from another observation: among addicts who had started treatment in or before 1981, those who eventually died of AIDS had been out of treatment for at least a year, at the time when HIV was spreading fastest, but they then enrolled in a programme [20]. The strategy of reducing the spread of HIV infection can best be improved by increasing the number of treated subjects, so as to limit the time spent under risk of contagion. The consequent shielding from HIV infection continues throughout treatment maintenance. Subjects who are seronegative when entering treatment, will most likely stay seronegative in the short [22], the medium [49] and the long term, provided treatment persists [35]. As previously mentioned, treatment endurance is the chief factor influencing the effectiveness of prevention on the likelihood of seroconversion: in fact, addicts who drop out of treatment show significantly greater rates of seroconversion [2; 10; 11; 48]. After treatment is discontinued, the protective effect of the treatment previously received has waned 18 months later (with a seroconversion rate of 3.5% for subjects still in treatment, vs. 22% for drop-outs, ) [32]: the relapse into substance use is thus followed, quite rapidly, by a relapse into addiction-related risk behaviours. Seroconversion rates, in any case, do not reach zero, even for successfully treated subjects [33; 41]: American authors report a 1.3% rate among subjects treated for at least one year during the epidemic era (1985-90). It is likely that some of the subjects who underwent treatment for only 1-2 years, later dropped out of treatment, so experiencing a quick relapse into heroin use, together with drug-related risk behaviours. Any actual evaluation of the effectiveness of methadone treatment as a means to prevent the phenomenon of seroconversion should always take into account its degree of effectiveness upon addictive symptoms. Short-term programmes or inadequate dosages fail to shield patients adequately from the dangers of seroconversion, either during the treatment itself (inadequate dosages) or after its completion (unreasonably short duration). In addition, the use of dosages below those needed to suppress
heroin craving results in lower retention rates [20; 21].

Reducing the likelihood of infection for exposed individuals appears to be all the more important, when it is considered that targeted categories also represent a source of contagion for the whole population. An epidemic of HIV infection among these categories follows quite a rapid course. For instance, the HIV-seropositivity rate of addicts entering methadone maintenance programmes in Vienna did gradually rise through the late eighties (from 8.5 up to 29.7%); this trend stopped along with the spread of methadone maintenance programmes across Austria, and a reverse, though much weaker decreasing trend, was documented (falling to 26.9%) [24]. This falling trend cannot be attributed to the progressive reduction of uninfected subjects, as happens at the end of any epidemic, since any addict population has quite a quick turnover. Similarly, a comparison between several European countries has shown that the more intravenous drug users are enrolled into methadone treatment programmes, the lower the prevalence of AIDS among the same subjects. Low prevalence countries can then be divided into two groups according to the incidence trend between 1987 and 1992. Low prevalence countries, with a rate that was falling between 1987 and 1992, were precisely those where methadone maintenance was commonest [38; 45; 49].

**Behavioural targets of methadone maintenance**

In cases where there is full responsiveness to a methadone maintenance programme, risk behaviours dwindle as abstinence continues [40; 48]. A positive effect in terms of infective risk has also been documented for heroin addicts who continue to use substances even when under methadone treatment. In fact, addicts in this category stop exchanging needles [26; 43; 47], mostly because they become more careful about their own health: it is more likely that they avoid using “dirty” needles themselves, rather than failing to offer their own “dirty” needles to their injecting partners [43]. It has also been reported that when the frequency of injections falls, the probability that unsafe practices take place during occurring injecting sessions falls too [8]. The decrease in the infective risk arising from needle-sharing habits may be partly due to a developing trend towards lonely injection, in situations where injecting partners used to be the rule [19; 23; 48]. On the other hand, some authors report that, even when addicts become keener on cleaning injecting paraphernalia, they do not necessarily avoid needle partnership [2].

Sexual promiscuity looms as another key target for the prevention of HIV-infection. Methadone-maintained subjects report fewer partners in the one-year interval previous to the interview [19; 25; 26; 45; 48], though agreement on this point is not complete [2; 23; 43]. Moreover, the number of recent partners is inversely correlated with the time spent in treatment [26], consistently with the hypothesis that retention in treatment is a crucial factor in achieving behavioural stabilization. As long as the sexual life of treated subjects is not hampered in terms of the achievement of personal satisfaction, sex-trading practices are likely to stop [45]. According to a variety of reports, condom use does not necessarily become the rule [19; 25; 29; 45]. A significant, though indirect,
proof of the real usefulness of methadone treatment in checking the spread of HIV appears to be the reduced risk of seroconversion among the sexual partners of treated subjects [41]. The partial discordance between different sets of data on hazardous practices, especially sexual ones, may depend on the fact that the total population of methadone-maintained subjects includes some subgroups, such as cocaine abusers or mentally ill addicts, whose sexual practices are not exclusively due to addictive heroin use.

**Dual Diagnosis and Infective risk**

When an adjunctive mental illness coexists with drug addiction, the risk of infection is expected to be extremely high. In particular, a high level of risk is associated with mood and anxiety disorders, which are the most frequent among heroin addicts [15], and with antisocial personality disorder [18]. Antisocial personality disorder is also predictive of a higher risk of infection for other high risk categories in the general population, such as cocaine addicts [13]. Apart from drug addiction, Mood Disorders themselves imply a significant risk for infective events: 46 seropositive patients suffering from a major depressive episode were compared with a group of depressed seronegative patients, with reference to the diagnosis of bipolar disorder: depressed seropositive patients are characterized by a higher rate of familial abuse of alcohol or other substances, and a higher rate of bipolar II disorder (78%), the latter combined with either cyclothymic (52%) or hyperthymic temperament (35%). On the other hand, no relationship emerged as regards the kind of risk (e.g. risks arising from intravenous drug use rather than homosexuality) [36]. It is suggested that premorbid cyclothymic and hyperthymic temperamental traits may have favoured risk behaviours (needle exchange, unsafe sex) and subsequent seroconversion. In conclusion, drug addicts appear to face a double risk: on one hand, they lose control over self-preservation in relation to the development of the addictive disease; on the other, as far as bipolarity is concerned, they display features of impulsiveness and risk underrating which belong to the clinical picture of bipolar disorders themselves.

**Methadone and risk reduction within low-threshold interventions**

Low threshold programmes traditionally deal with a case-management approach, and adopt preventive measures against the complications of addiction, with no specific treatment programme to target the core of the addictive illness. As for specific approaches, the view of clinicians is that suboptimal methadone dosages, or discontinuous methadone administration are useless, since they do not lead patients towards any stabilization. Because of this dichotomy, methadone is an instrument that has been exclusively employed within specific programmes, whereas harm reduction approaches have focused on prophylaxis and contingency management, only resorting to symptomatic drugs, if any. It is our opinion that the true role of low threshold interventions does
not depend on the means employed, but consists in providing a kind of interventions that is able to deal with a lack of compliance or poor psychosocial adjustment. Therefore, harm reduction programmes should employ, among others, specific pharmacological means, including methadone. In fact, suboptimal dosages, besides their effectiveness in buffering withdrawal, may act to reduce risk behaviours and infective incidents. This effect can be expected in controlling paroxystic cravings, or in exerting a buffering effect on psychopathological peaks, which lead to impulsive acting-outs. Moreover, street addicts' need to control their addictive urge, and their worries about getting the substance they crave allows them to respond to the health-promoting campaigns, that reach out to them, and helps them to apply the precautions they have learned. The impact of prevention campaigns, which, in any case, are well worth organizing [6], even when they have no pharmacological weapons to rely on, would be far stronger with those weapons, although stable abstinence may not be attainable.

**Methadone Maintenance and HCV infection**

HCV infection is quite frequent (64–88%) among heroin addicts [34]. The chronicity and worsening course of chronic C hepatitis towards terminal liver failure, is the cause of as many as 9% of all deaths during methadone maintenance programmes [1]. HCV seroconversion seems to be more likely than HBV or HIV seroconversions [6], maybe because of the greater virulence of its infective agent, or its modes of contagion, which cannot be controlled by the behavioural stabilization of the addictive disease. However, the impact of methadone maintenance upon the liver functions of HCV-infected individuals appears to be positive: levels of liver enzymes are higher for drug-free subjects, whether they are being treated with naltrexone or methadone maintenance [27; 27]. Chronic C hepatitis is characterized by alternating periods of simple viral persistence, accompanied by no clinical signs, and phases of exacerbation, during which clinical symptoms may be displayed. During exacerbation, the liver metabolism may be enhanced, so that higher methadone doses may be required [30].

**Conclusions**

Specific therapies for opiate addiction can be regarded as the most effective instrument for the prevention of the infective diseases addicts are most exposed to. Agonist maintenance, which has so far been the approach that offers the best and commonest forms of clinical control in cases of opiate addiction, is also useful in terms of prevention, by its specific reversal of addictive behaviours, which are, conversely, reinforced by ongoing drug use. In low threshold programmes, too, when no full compliance or control of addiction is judged to be achievable in the short term, opiate agonists still function in a specific way, and are active on core addictive symptoms; this strengthens the hypothesis that lack of behavioural control in patients is due to their impaired opioid function. Nevertheless, the availability of useful instruments alone is
not enough to ensure their correct utilization; in this sense, undue insistence on ideal objectives may, in fact, act to the detriment of achievable ones. As addiction can only be faced by limiting its harmful and irreversible consequences, it should be clear why, on medical grounds, stabilization is the best achievable result. Stabilizing a drug addict by opiate agonist treatment means controlling drug use, and protecting patients from consequent morbidity and mortality, but it also allows both objectives to be achieved simultaneously through the use of a unique instrument.

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Heroin Addiction and Related Clinical Problems


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Breast-feeding for a methadone-maintained mother: a case report

Francesco Lamanna, Susanna Scuotto, Maura Tedici

TO THE EDITOR: E.B. is a 27-year-old married woman, who completed her high school education. She currently works as a bank clerk and is studying for a university degree in Economics. Her temperamental profile is characterized by a cyclothymic substratum, with sub-threshold social anxiety. At the age of fifteen she started using stimulants, including ecstasy, at weekends; this habit lasted for as long as three years. When she began suffering from dysphoric symptoms caused by ecstasy intoxication, she started using heroin intranasally; she found this useful in relieving stimulant-induced dysphoria. Heroin snorting first, and smoking later, gradually became continuous, and a real addiction to the substance eventually set in. For that reason, E.B. applied for treatment at the local Service in October, 1998, and she was enrolled in a methadone maintenance treatment programme; dosage was gradually increased up to a stabilization value of 100 mg/day. This dosage was maintained for a reasonably long period, after which gradual tapering was initiated. Later on, when her dosage was as low as 40 mg/day, the patient decided to have a baby with the partner she had been engaged to for quite a long time while in treatment. She became pregnant while taking 30 mg/day, and tapered methadone down to a 15 mg/day, a dose which was maintained throughout pregnancy and after delivery.

The patient received regular monitoring during pregnancy; delivery was performed by a Caesarean section. The newborn was male, weighed 3,950 kg at birth and displayed withdrawal features accounting for a 15 Finnegan score, which fell to 6 during the next 24 hours. No other abnormalities were found. Methadone serum level of the newborn was 1800 ng/ml.

By that time, the patient was negative, and had stayed negative for HIV and HBV, as well as for the other main sexually transmitted diseases and ‘needle’ infections. Her compliance has been satisfactory throughout the period spent in treatment, and freedom from relapses had been documented by regular twice-a-week urinalyses, while social adjustment had been gradually restored. We thought that the lack of contraindications should allow her to breast-feed her infant, and she was enthusiastic about this idea. We
therefore asked colleagues of the Neonatology Department to follow the case, on the understanding that they would recommend detoxification by phenobarbital after the accomplishment of breast-feeding. However, her methadone serum level was as low as 350 ng/ml after 48 hours, and fell to levels undetectable by High-Pressure-Liquid-Chromatography (HPLC). One month after birth, no abnormalities had been displayed. E.B. had maintained her 15 mg/day dose and breast-feeding had continued. Before breast-feeding was interrupted, her milk was tested for methadone, which proved to be undetectable.

Although a few studies have dealt with the issue of breast-feeding for methadone-maintained mothers, it can be stated that:

1) Denial of the opportunity of breast-feeding by mothers successfully maintained on methadone because of their agonist-maintenance status should be interpreted as a merely discriminatory act.

2) It is unreasonable not to treat newborns tolerant to opiates with an opiate agonist for their possible opiate withdrawal syndrome. There is no actual need to resort to non cross-tolerant neurodepressant drugs such as barbiturates. The tradition of non-opioid treatments for opioid-dependant newborns, and the fear of handling opiate agonist drugs, are not acceptable justifications for any such practice to persist in a scientific context.

3) The preoccupation about an overdosing fatality in breast-fed newborns of methadone-maintained mothers is in contrast with the evidence that methadone is passed into milk at a rate that is generally low, though it varies sharply between individuals. As far as the neonatal withdrawal syndrome is concerned, breast-feeding with methadone-positive milk, may be helpful as a means of natural detoxification for the newborn. In this case, the use of non-opioid depressants cannot be recommended, as they could interact with opioid depressants in a way harmful to the baby.

As this case report illustrates, there are no good reasons for not allowing women who have been successfully stabilized on methadone to become pregnant while maintenance is still ongoing, or for not allowing breast-feeding to normally follow delivery. Breast-feeding can be recommended even for newborns of methadone-maintained mothers, as there is no residual withdrawal in the infant after the interruption of breast-feeding at its usual term. What should be avoided, rather than being merely unnecessary, is the use of neurodepressants to control withdrawal in newborns chronically exposed to opiates in utero.

References

TO THE EDITOR: From January 1999 to October 2001 a public drug-dependence department located in the suburbs of Naples (DSB 50 ASL NA 1) provided methadone maintenance treatment to 90 patients (average age 33 years, 88 males and 2 females) who had no regular residence permit to stay in Italy and no identity document. They all came from outside the European Community.

These patients had been referred to us by representatives of the Mobile Unit for Harm Reduction who had been working every night near the main railway station in Naples for over five years. That is, in fact, an area where illegal immigrants spent a lot of time, meeting each other, trading illegal substances and sleeping in disused railway carriages.

These patients were very rapidly given access to methadone maintenance treatments and health care. They were fully informed, in some cases by an interpreter, about the evidence in support of long-term methadone treatment, the risks associated with intravenous drug abuse and how to avoid it. The average dosage of methadone was 60/mg die.

Nearly three years experience with this target of heroin addicts has consistently demonstrated the effectiveness of methadone in reducing, if not eliminating, heroin use and in allowing patients to lead healthy, self-fulfilling and socially more productive lives. It is clearly not a panacea, but its ability to attract and retain patients, and to lessen the consequences of addiction compares extremely well with the results of the treatment of most other chronic illness.

In the case of some infective illnesses, such as HIV or acute and chronic hepatitis, patients were referred to specialized departments, while thrombophlebitis and subcutaneous soft tissue and syphilitic infections were treated in our department. 40 patients were vaccinated against HBV.

Since July 2001 Italian law has guaranteed medical services to illegal immigrants from outside the European Union. That has made it easier for them to receive medical
services and therapy.

Independently of the problem of drug (ab)use, these patients, after admission to methadone maintenance treatment, improved their standard of living in terms of nutrition, ability to look after themselves, employment and accommodation.
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