

Treating Heroin Addicts, i.e. “Breaking through a Wall of Prejudices”

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Summary

The medical, psychiatric, psychological and social manifestations of heroin addiction require more than an integrated intervention. To effectively treat addiction, rehabilitation and/or prevention is necessary but we must also treat the patients according to the phase of illness. In other words, it is often necessary to adapt the intervention to the clinical phase of illness, by trying to raise the programme “retention rate”. This condition is indispensable in the rehabilitative process. The nature of drug addiction will often make it necessary for patients to be contacted in the street, so that they can benefit from counselling and “harm reduction”. Finally, primary or secondary prevention cannot be separated from a global intervention philosophy.

Key words: Different level of intervention - Prevention - Harm Reduction - Diagnosis and Treatment of Associated Pathologies - Specific Treatments - Rehabilitation and Social Integration - Prevention and Treatment of Relapse

Given the complex nature of heroin dependence, there is no one method that is completely effective in the treatment of this pathology. Drug addiction varies in intensity, and drug addicts are a heterogeneous group in terms of personal resources and coping ability.

The clinician’s priority is to respond appropriately to each individual patient, by personalizing therapeutic planning (including different types of interventions) in an effort to improve the single drug addict’s functioning. Treatment should be adapted to the patient’s changing needs, so providing long-term continuity.

Presently, almost all researchers in the field of drug addiction agree that the “retention rate” is a fundamental requisite for the successful outcome of any program (2). This is obvious if one considers the official definition of drug addiction as a chronic

illness involving relapses. Thus therapeutic planning must be adapted to the patient and not vice versa.

If, as systematic observations reveal, many drug addicts stay addicted over a long period, some for the rest of their lives, attempts to treat this large group of subjects must not be abandoned. Priority should be given to long-term treatment by giving the drug addict the chance to gradually recuperate his or her bio-psycho-social functioning. This could be defined as clinical improvement, even if “restitutio ad integrum” has not been achieved. It is the main goal of adequate pharmacotherapy and psychosocial treatment (12).

Achieving this limited goal may be the best possible result for some, while for others it may open the door to being able to function well, in an opioid-free state, over the long term. In both cases, however, these subjects have a right to a normal life, personal gratification, social respectability, and physical and mental well-being (7).

The second step in therapeutic planning is monitoring patients during and after treatment in order to prevent and treat the inevitable relapses. Relapses are defined as “expected” in the therapeutic alliance. They should become predictable to both the clinician and the patient. Both must be ready to face a relapse with all available resources, in order to recover or exceed the prior level of functioning. When a relapse occurs, it should be seen as part of a normal process, not a failure, and the treatment plane should be altered in a way which is likely to restore patients to the pre-relapse level of function. Withdrawal of agonist medication or discharge from treatment never accomplishes restabilization. These are destructive responses to substance abuse in a patient.

It is important that staff acquire a global view of the various types of treatment available. This view should comprise the probable outcome, length of time required, cost, indications and contraindications, as well as an understanding of when, for a particular patient, crossover to another modality would lead to optimal therapeutic results.

While comprehensive treatment programs attempt to deal with many of the problems associated with addiction, we feel that Therapeutic Community re-educational programmes (TCps), when based on segregation and accusation, must not be utilized. Examples of this kind of treatment were common in Italy and in other European countries in the 1970's and 1980's, when the stigma experienced by heroin addicts was severe and treatment with opioid agonists was strictly regulated but not accepted by politicians. The re-educational programmes on which most of Italian TCps are based are highly selective, and have proved to be beneficial to only a very small number of addicts, when pharmacological support is denied. My personal experience allowed me to note the cognitive disorganization of patients who followed TCps; this tended to reinforce guilt and convey the idea that drug addiction is an acquired vice caused by deviant behaviour. In this way patients found themselves defenseless and unprepared for relapses, which they interpreted as being an explicit sign that they could never recover. In these programmes the refusal of the biological basis of addiction or the withdrawal of family counseling is a very harsh measure; it often means cutting ties with the patient,

who is described as "lacking in will and motivation". For heroin addicts, "reaching the bottom", the most famous slogan of some Italian TCs (CEIS group), very often meant dying of an overdose, contracting AIDS, or the refusal of all types of treatment (9).

Comprehensive treatments need a new philosophy of intervention. Staff must know the various levels of the treatment programme, and the policies adopted at different levels must not be contradictory.

Our theory of comprehensive treatment includes different levels of intervention, as follows:

Level 0: prevention. Level 1: harm reduction. Level 2: diagnosis and treatment of associated diseases. Level 3: specific treatments. Level 4: rehabilitation and social integration. Level 5: prevention and treatment of relapses. These levels can be implemented individually or in groups in a coordinated manner, depending on the needs and willingness of the patient.

LEVEL 0 (Prevention)

Currently, no effective primary prevention model is operative. Educational models based on particular cultural backgrounds are rarely acceptable to all.

Although drug dependence may have its roots in societal organization, or in consumerism, educational models alone are not effective preventive measures, and may cause diametrically opposite results in social groups with different cultural backgrounds. Research has not yet identified specific educational impairments or temperamental types associated with drug addiction. A large number of subjects begin using drugs recreationally or to facilitate socialization without knowledge of the real risks or consequences of drug abuse.

As a primary prevention model, we suggest a public health education programme, on the various psychoactive substances that are targeted during abuse, and the effects and consequences of use and abuse. This programme should be free from ideological and moralistic interpretations, which often do no more than leave an attractive mythical or mysterious image (13, 14).

Health education constitutes a valid primary prevention policy, but secondary prevention (harm reduction, therapy, prevention and treatment of relapses) should not be overlooked.

Research indicates that the spread of heroin use is correlated with precise market interests which are kept alive in certain well-defined conditions such as clandestineness, which implies high cost, consumer-pusher phenomena and the unavailability of any effective therapy. Within this framework, the depenalization of drug use, and the treatment of drug addicts are essential preconditions for the elimination of this problem (1, 7).

LEVEL I (Harm Reduction)

The aims of level 1 may be summarized as follows:

- a) reduce the social and the medical consequences related to addiction, such as: criminal activity, spread of AIDS, consumer-pusher phenomena, the clandestine

nature of the market partly responsible for the high numbers of heroin users, and the high level of risk for the general population.

- b) protect heroin addicts from syringe-related pathologies (HIV, hepatitis, vascular damage, endocarditis, overdose, etc.) and from withdrawal syndrome; this will be an advantage for the patient, and will reduce social costs.
- c) more accessible public health services for the heroin addict population (11). Establishing the first contact between medical staff and addicts means (1) reaching a larger number of subjects; and (2) offering accurate information about physical and mental well-being and therapeutic prospects. These measures have not yet been implemented, especially in Italy and most other parts of Europe.
- d) the possibility of an early diagnosis; this aim is currently unattainable because drug addicts live in clandestineness. The patient usually seeks help when the situation is no longer bearable, and the course of addiction is far advanced.

Suitable interventions at level 1 include:

- a) expansion of agonist substitution therapy programmes based on methadone or other substitutive compounds (LAAM, Buprenorphine). The Swiss experiments with heroin do not provide conclusive evidence. They did not have a good control group, and the heroin patients received much more psychosocial treatment than the methadone patients. Also, the heroin clinics were much more expensive to run than methadone programmes, and it is unclear how heroin clinics fit into the overall framework of treatment programmes.
- b) free distribution of disposable syringes.
- c) instructions on the self-administration of medications.
- d) information about first aid in the case of an overdose or a withdrawal syndrome.
- e) information about the risks and consequences of the continued use of illegal drugs, and about types of treatment and rehabilitation.
- f) health education of HIV subjects

The operative phase of level 1 would be carried out by volunteers and specialized workers in "street units". Family physicians as well as ambulance paramedical personnel should also be involved. In this way a tight network of contacts between health services and drug addicts is assured, while access to health services is facilitated.

The effectiveness of a pragmatic approach has been convincingly demonstrated in the experience of countries such as England and Holland, which have succeeded in limiting the spread of heroin addiction (e.g. in 1991 in the United Kingdom 8,000 heroin addicts were officially registered, the spread of AIDS was limited and restricted to subjects at risk, mainly homosexuals). During the same period in Italy, due to moralistic and repressive attitudes, there were more than 320,000 heroin addicts, 1,200 deaths by overdose, and a high incidence of HIV; 70% of heroin addicts were seropositive.

The drawback of this first level is that it is not an actual form of treatment, so it cannot help patients recuperate bio-psycho-social functioning. In order to achieve this goal we must pass to the next level of our programme, which includes services and personnel with better qualifications.

LEVEL 2 (diagnosis and treatment of associated pathologies)

This level marks the beginning of specific treatment for drug addiction. The patient is examined by a medical specialist and other professional staff in order to decide on a diagnosis and devise a therapeutic plan appropriate for that subject. The scientific literature shows broad agreement in defining heroin addiction as an illness, and experience shows that it is the patient's degree of impairment, together with other factors, that determine if a particular intervention will work or not at that time. The principal task of specialized staff at this stage is to define a diagnosis and identify potential resources (personal attributes, family members or social skills), that may help in rehabilitating the patient. This will be possible if interviewing techniques reactivate two-way communication, in so allowing the needs of the patient to be identified, and concrete proposals to be formulated. Special attention should be given to unsuccessful attempts, which are often indicative of errors in the interventions proposed or in the monitoring of the patient.

This level requires more qualified personnel and specialized services than are currently available. Specialized centres for the diagnosis and treatment of addiction are needed. These centres should be equipped to carry out research, in collaboration with Ph. D. Research Programmes in Drug Addiction, and specialized personnel must be educated and trained.

Once a diagnosis has been made, the patient undergoes the appropriate form of therapy. The initial choices should not be restrictive or rigid but open and interchangeable with other treatment modalities. Staff will only be able to verify the choices made if the patient acquires and stays in a functional state.

At the same time associated pathologies and psychiatric disorders should be diagnosed and treated (4, 8).

LEVEL 3 (specific treatments)

This level includes therapeutic and rehabilitative intervention after the patient has undergone clinical assessment. Generally, patients may be divided into two groups:

- a) those who do not require opioid agonists.
- b) those who require long-term opioid agonist therapy (Methadone Maintenance; LAAM Maintenance; Buprenorphine-Naloxone Maintenance)

A. Patients who do not require opioid agonists

The patients included in the first group should satisfy the following requisites: they should meet DSM-IV or ICD-10 criteria for a substance use disorder; they should have a low level of craving, good social adjustment, and good family support, with the availability of a referring family member; these subjects are reliable, and have good interpersonal relationships with staff (3).

It is important to stress that methods based on a "drug-free state" are highly selective, and are applicable to a very small number of patients (5, 6, 10); some antisocial and very resistant addicts, however, make good progress in these programmes, while not responding to anything else. Understandably, caution is needed before detoxifying patients, and there is also a need for attention in checking behaviour at risk, and

immediately admitting the patient to an agonist treatment programme if difficulties arise.

Methods for achieving a drug-free state may be defined as follows:

1. Abstinence is controlled by psychotherapeutic support, with or without opioid antagonists.
2. Self-help groups which encourage social reintegration during treatment. Antagonists may also be used in this case.
3. We propose TCps comprising greater flexibility and research in selecting participants, as compared with the rigorous ones that currently dominate the scene. NIDA is supporting studies on more “flexible” TCps (those that use medications and treat dual diagnosis patients).

B. Patients who require opioid agonist long-term therapy

This group includes the large majority of drug addicts who seek help. They do not meet requisites for “drug-free” programmes, which would be detrimental for these subjects.

The first task staff must face is that of redefining the patient’s expectations by suggesting the form of long-term treatment that promises to be the safest and the most successful.

One should aim to set up services that are able to support and be integrated with a long-term agonist therapy.

1. Basic counselling. Many patients on methadone or other substitutive therapies who have obtained metabolic stabilization experience a return to normality; they become socially reintegrated, especially if they have personal resources, with help from family members (home, work, hobbies, etc). For these patients therapeutic success may be attained through specific information and treatment counselling.
2. Treatment of psychiatric disorders with psychotherapy and/or pharmacotherapy, along with drug counselling for patients with psychiatric disorders.
3. Self-help groups could provide solid support for subjects who lack rehabilitative resources. Greater attention should now be focused on these groups, because they cost little, and have been shown to be effective in other areas (alcohol abuse, psychiatric pathologies, etc.), while many subjects can be treated simultaneously.
4. Residential Communities. These communities would help especially very young patients or subjects who need specialized social structures in addition to pharmacotherapy; these comprise drug addicts with serious psychiatric disorders, and those who find themselves jobless and homeless.

In concluding we would like to stress the following:

1. The therapeutic communities would be linked to social agencies and other health services. They would no longer be reclusive structures that isolate the patient from his or her family, or cut social ties. They must not create an artificial world in which recovery is obtained but quickly lost when the patient is released. Contrary to what happens in Italy, in the US many TCs work very hard to integrate patients back into the real world prior to discharge. It is important to have a transition phase, so as to help patients overcome the problems associated with the artificial environment.

2. The primacy of "drug-free" programmes should be abolished. Recovery cannot be strictly associated with a "drug-free" state; it should be related to psychological and social functioning.

LEVEL 4 (rehabilitation and social integration)

This level foresees the complete rehabilitation of drug addicts, independently of the kinds of treatment mode being used. The achievement of this goal varies (in terms of mode and length of treatment), according to the needs and the severity of illness of each individual. The forms of intervention which allow the patient to achieve this status may, for example, comprise: getting a job, the return to family life; the use of methadone, LAAM, and buprenorphine detoxication.

We would like to focus on the needs of patients who cannot be deprived of agonist therapy due to biological determinants. A substantial part of the drug addict population – who have good social and psychological adjustment – require agonist therapy, but not social support services. We consider these patients to be capable of complete recuperation, and feel that they should be allowed to manage their pharmacotherapy in the way diabetics do. For these subjects agonist availability should be convenient, and interfere as little as possible with daily life, work or leisure time. The patient could be entrusted with dosages that cover a longer period of time; family doctors would be able to prescribe methadone or other substitutive compounds. Any community health service could dispense methadone or other substitutive compounds under certification, so as to help the patient. On the international level contacts could be set up between the health services of different countries, so permitting the patient to travel freely. The organization of a health service network would be an advantage for the patient, who would not need to travel great distances to reach specialized centres. At the same time these centres would not be overloaded with work such as dispensing methadone or other substitutive compounds to patients who have been rehabilitated, so reducing social costs.

LEVEL 5 (prevention and treatment of relapses)

Given the definition of heroin dependence as a chronic illness involving relapses, it is logical to emphasize the role of prevention and therapy for relapses. This requires therapeutic modalities that help to restore the skills and functional level previously achieved by the patient. Thus patients would be rapidly readmitted to methadone or other substitutive therapies (this is obligatory with recurrences), in order to prevent harm to the patient i.e. a return to street life. Treatment would be simplified in these programmes, as these patients have been rehabilitated in the past. In order to accelerate readmission to any health service, the patient would be provided with documentation containing clinical chart data.

In conclusion, we have attempted to outline a rather complex strategy for the treatment of heroin addiction, on the grounds that it has a scientific and pragmatic basis. Obstacles to the realization of this project are political interference and cultural prejudices. It may be hoped that education of the public will help to correct current misconceptions about the problem of drug dependence.

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