

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 a 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 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.

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