

Can Heroin Maintenance Treatment Be Called a Therapy?

Gian Paolo Guelfi, Mauro Cibir, Pier Paolo Pani and Icro Maremmani for the Board of Directors of Italian Society of Addiction Medicine

Summary

Heroin administration may be reasonably accounted for in order to handle the cases of patients who proved refractory to methadone, despite repeated attempts and the employment of enhancement techniques to favour retention and rehabilitative processes. In most countries this is not the case, since standard effective treatments are often neglected or applied with unjustified limitations resulting in hampered effectiveness. As a consequence, effective treatment is far from being actually available to all those who apply for it, let alone those who may benefit from it. The first step to empower the addiction care system is to spread and enhance resources to grant patients with correct and powerful application of effective techniques, methadone/buprenorphine maintenance being regarded as the gold and first-line standard for the average addict. If that will ever be the case, as we hope, we would need to provide patients identified as refractory with a salvage option, along the concept of harm reduction. In any other context, the introduction of heroin administration programs would rather reduce the benefit than the harm.

Key Words: Heroin Maintenance - Heroin Addiction Treatment

Proposals to initiate controlled heroin administration by public services for the emergency management of opiate addiction go back many years, and they become a topic matter of debate from time to time. The Italian Society of Addiction Medicine has now decided to issue an official statement on this question.

As a rule, proposals to employ heroin as means of treatment gather strength on the

Address for reprints: Icro Maremmani, M.D., Vincent P. Dole Dual Diagnosis Group, Santa Chiara University Hospital, Department of Psychiatry, University of Pisa, Via Roma 67, 56100 Pisa, Italy, EU
Phone +39 050 993045, E-mail: maremman@med.unipi.it

crest of a new wave of hope in some ill-defined healing miracle against the plague of drug addiction. The current line of thought is that legalized, or — to express this idea more correctly — controlled heroin administration may offer a complete solution to the problem of how to take control of accelerating emergencies (such as drug-related crime) or how to prevent the collapse of the system, both in terms of the burden that is being placed on the legal system and in terms of prison overcrowding.

First of all, the issue of the legalization of heroin is a different one from that of its controlled administration, and should be discussed separately and on different grounds. On this basis, the present paper is intended to provide a statement exclusively directed to the second question. As to the former, there would be little point in discussing it here, as it is obvious that, on one hand, making a substance legal raises the probabilities of toxic consequences — a consideration that applies to the widespread phenomenon of alcohol-related driving accidents, and to the frequency of alcohol — and smoke-related illnesses and causes of death. On the other hand, it is predictable that any prohibited substance, as it offers a pleasant experience, will attract the interest of the black market, where its commercial value will be enhanced by prohibition, so that criminal organizations and their affiliates will be made richer by illegal smuggling and selling, and this will develop into a major threat to social stability. The main point to be made is that we cannot believe that anyone aware of heroin's powerful conditioning properties would knowingly make it available to the whole population as a kind of joyride without placing any restrictions on its use. Also, our aim is not to discuss the establishment of such facilities as shooting rooms or syringe distribution, which proved to reduce drug-related problems without favouring drug consumption, but also without implying controlled heroin administration.

The ISAD/SITD, consistently with its funding aim at supporting the adherence of addiction treatment to scientific knowledge, is committed to promoting enrolment in addiction treatment, to avoiding the consequences of addictive heroin use that are the hardest to treat, to improving the health of addicts and their quality of life, and, whenever possible, to providing addicts with long-term disease control by a specific treatment programme, in answer to their request for help and as a positive response to their motivation and willingness to comply.

Some therapeutic instruments have been shown to be effective in achieving these purposes, when administered alone or in combination with one or more other instruments, either in a single course of treatment or with the resumption of treatment, while choosing between a range of treatment programmes of varying length. Data from the literature make it possible to assess, even if to a limited degree, which category of patients to direct to which treatment options, and what degree of effectiveness is made available by each type of treatment to the average heroin addict.

The most important lesson we have learned so far is that the validity of any new treatment option is conditioned by the likelihood that the addict will comply with it in the longer-term; the technical name of this key criterion is 'retention in treatment'.

Therapeutic communities appear to fulfil a variety of functions, but in the medium-

term only a minority of participants is retained, while most participants leave the programme earlier than planned, and a substantial number of completers experience relapse after discharge.

Similar objections could be made about antagonist (naltrexone) maintenance, which is safe and effective for those who are currently in treatment, but is only tolerated by a small minority of addicted patients. Moreover, patients need to undergo preliminary detoxification in order to become suitable for naltrexone maintenance, so that dropouts find themselves exposed to a heightened risk of overdose when they relapse into heroin use, due to their loss of tolerance to opiates.

Methadone maintenance, which is often incorrectly described as substitution treatment, is the best known treatment option in countering opiate addiction. Research has demonstrated that methadone maintenance is effective in achieving the following objectives: reduction or extinction of heroin use; sharp reductions in cases of mortality due to overdosing; lower rates of HIV seroconversion and other common infective diseases related to intravenous drug use; the reduction or extinction of drug-related street crime. Patients on methadone maintenance are suitable for any working activity and are able to drive, since no significant neuropsychological abnormality has been reported.

All in, methadone treatment can be expected to normalize behavioural and cerebral parameters and restore subjects' normal pattern of functioning, so enabling them to survive, to maintain an acceptable state of health, and to sharply improve their quality of life, which may become inversely correlated with their level of tolerance to opiates; this is true even of subjects who would be unsuitable to qualify for detoxification procedures.

The above objectives are achievable, as long as treatment programmes are actually made accessible to local patients, and as long as treatment is provided at an early stage in the history of addiction, while respecting the criteria for effectiveness, with special regard to the three following features.

The first key factor is dosage, which must be sufficient to allow control over the drive towards heroin use and the urge to experience a *high* by taking heroin. The desire for heroin, when it is overwhelming and irresistible, is technically known as *craving*. Craving for heroin is suppressed by stable methadone administration at dosages as high as 80-100 mg/day, on average. Lower dosages do at least block or hamper the effects of self-administered heroin doses, but they are usually ineffective in suppressing the craving for heroin. Minimum dosages, even lower, can do no more than provide limited control over withdrawal symptoms. Thus, methadone maintenance can be expected to be effective only at dosages of at least 80-120 mg/day, which can be referred to as the 'average effective dose'.

The second key feature is the use of a combination of medical treatment with an ensemble of non-medical intervention, which, as a whole, can be referred to as 'psychosocial intervention'. Controlled studies have shown that if methadone treatment alone is effective, then that effectiveness will be heightened when medical treatment is combined with psychosocial intervention. The increase of effectiveness is proportional

to the weight of the added intervention.

The third key is treatment chronology: treatment should be undertaken early in the course of the disease, as soon as the patient applies for it; this factor is often neglected, due either to lack of knowledge or a lack of personnel and resources. In this latter case, the delay in providing treatment results in waiting lists, which place an upper limit on the quality of health care for drug addiction. Treatment programmes should be continued for as long as necessary, which typically means some years, since the term ‘addiction’ refers to chronic disorders that are inevitably liable to relapses.

In Italy methadone treatment is far from being widely accessible, despite the fact that the law requires it to be systematically available; in some areas it is just not provided due to local policies, and in others it is not available to all who apply for it. In most areas, the information provided to patients is so poor and incorrect that only a few of them have any precise idea of what benefits methadone treatment could bring to them. This makes it unlikely that the average Italian addict will ever ask for methadone treatment rather than some unspecified, or only vaguely specified, detoxification procedure or a generic type of support. In many cases methadone is administered at ineffective dosages; in fact, inadequate dosage is the most frequent single reason for treatment failure. In some areas, local health authorities aim to set an official, not-to-be-exceed dose threshold corresponding to values far below the effective dose ranges we have mentioned above.

The cultural background underlying this situation is the long-standing body of prejudice against methadone, which is regarded as some absurd “legal narcotic” appealing to drug addicts, or as the reason why addiction becomes chronic, or as a way to surrender to addiction without ever achieving any true cure. Beyond that, there is the denial of the idea of drug addiction as a metabolic disorder with its own core neurobiological dynamic.

On all these grounds, the first priority in the field of drug addiction treatment in Italy is the spread of methadone treatment, in terms of its accessibility and correct application. Increasing the accessibility of methadone treatment also means providing information to potential applicants for treatment who would otherwise be unaware of the expected benefits to their health and social status. We estimate that the addicts who remain without treatment because they are unaware of the therapeutic options or because of mere misinformation are at least as numerous as those who are currently in treatment.

Methadone is a chemical compound which is easily available for administration to large populations of patients and it is rapidly effective. Thereafter, all those who wave emergency flags and call for a quick fix solution should consider that the true solution, methadone, has long been available for application — the true being that resorting to heroin is not only unnecessary, but also pointless, because it is generally ineffective.

The proposal to allow controlled heroin administration must immediately raise major objections.

Firstly, evidence provided by double blind controlled trials (the only acceptable

design for determining the superiority of any therapeutic option over any other) is hard to find.

From 1926, heroin administration to heroin addicts has been practised in Great Britain. It first started as the prerogative of any physician, and was restricted after the 1960s to psychiatrists with experience in the treatment of heroin addicts. The debate about its usefulness and ethical acceptability has never stopped. Nowadays, heroin treatment is a neglected option, and some judge it may have played a role in the rising incidence of heroin addiction in Britain during the 1960s, which was the official reason for greater caution afterwards. The Swiss experience is more recent, and, by contrast with the British situation, heroin administration was introduced as an option against addiction in a context where methadone treatment was actually accessible and correctly applied, as it was available to all potential patients. In Switzerland, methadone treatment remained the standard option for heroin addiction treatment, due to its unequalled effectiveness. The Swiss experiment involved about one thousand addicts chosen from those who were not eligible for standard treatment or had failed to improve while on methadone treatment. The one basic reason for providing heroin treatment to addicted patients, as the scientist mainly responsible for that decision stated in his concluding report, was that other effective treatments were widely available to those same patients. In other words, heroin administration can only be scientifically justified in the case of resistant methadone dropouts or untreatable street addicts. Otherwise, it is inadvisable to render heroin administration programmes accessible to patients whose cases have not already been put to the test and challenged by standard or psychosocially enhanced methadone treatment. A new policy of making heroin administration general available in Italy would bring about a shift in the status of potential methadone responders, who are currently able to adopt a scientifically funded rehabilitative perspective, by providing the lure of a kind of treatment which cannot be expected to provide addiction control, and whose best justification is that it might offer a way of reducing harm for untreatable patients.

In a context where methadone treatment faces hostility from the cultural background, just such a waste of therapeutic potential is quite likely to take place.

The Swiss design featured the possibility that patients could receive up to three heroin doses a day, as long as these were self-administered at the centre. However, precautions like these fail to rule out the possibility that patients may have resorted to the black market to purchase further heroin in order to exceed their tolerance level and reproduce the 'highs' they desired. In order to prevent such phenomena, most patients had methadone administered to them, too; this fact should act as a reminder of the difference between methadone and heroin in making any form of behavioural control an achievable aim.

The debate about heroin programs turns the spotlight away from the actual limits of the Italian system, where the inadequate provision of treatment and the poor adherence of medical practice to current scientific knowledge are the key problems.

The latest Danish experience has just confirmed the harm-reducing effectiveness of

controlled heroin administration, but evidence emerged against the hypothesis that it might be made accessible as a side option to already existing methadone programmes. In fact, retention in treatment is undoubtedly greater in methadone maintenance programmes, so that heroin administration, even when controlled, does not seem to allow with behavioural stabilization, of the kind that can be expected from methadone treatment.

Conclusion

Heroin administration may be reasonably taken into account as one way of handling the cases of patients who have proved refractory to methadone treatment, despite repeated attempts and the employment of enhancement techniques to favour retention and rehabilitative processes.

It must be pointed out that in most countries such attempts are simply omitted, since standard effective treatments are often discarded, overlooked, or only applied with unjustified limitations that result in impaired effectiveness. As a consequence, effective treatment is far from being really available to all those who apply for it, let alone all those who may benefit from it. The first step to empower the addiction care system is that of spreading and enhancing resources so as grant patients access to the correct and powerful application of effective techniques, bearing in mind that methadone/buprenorphine maintenance is viewed as the gold standard and the front-line resource for the average addict. If this perspective can ever be implemented, as we wish, we would need to provide patients identified as refractory with a fail-safe salvage option, in accordance with the concept of harm reduction. In any other context, the introduction of heroin administration programmes would have the outcome of reducing the benefits rather than the harm.

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