

## **Methadone Treatment in the Criminal Mental Hospital of Montelupo Fiorentino, Tuscany, Italy**

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TO THE EDITOR: Italian Government decree No. 230/99<sup>(1)</sup> sanctioned the principle that the Italian National Health System has the authority to provide prisoners who have drug and/or alcohol addiction problems with treatment to be targeted at prevention, diagnosis, care and rehabilitation at levels similar to those made available to free citizens. Starting in the mid-Eighties, the percentage of prisoners in Italian jails with a record of drug addiction has risen to levels that rank among the highest in Europe. From the official data it emerges that a figure of 35% for the proportion of prisoners in Italian jails who have been condemned for crimes linked with the breaking of drug laws must be considered an underestimate, and everything connected with law No.49/06<sup>(2)</sup>, which is about to come into effect, leads one to suppose that this approximate figure is bound to increase. The decree known as DPR 309/90<sup>(3)</sup> had introduced measures that are alternative to forms of punishment; in this context, sections of the law allow less severe custody regulations to be applied in some circumstances. Besides this, under the terms of DL 230/99, the transfer to Local Health Authorities of responsibility for the management of substance abuse treatment for those in jail are now expected. With the aim of sanctioning the idea that substitution treatments in jail can be extended to include maintenance, a circular letter written by the general manager of the Penitentiary Department Administration and dated 22nd May 1998<sup>(4)</sup> was sent to interested parties.

Most drug addicts in jail are heroin addicts. Those who cannot take advantage of measures alternative to imprisonment could obtain a better quality of life through pharmacological treatments that are able to control the withdrawal symptomatology, anxiety and mood disorders, and the behavioural disorders connected with drug addiction, so making their adaptation to prison life easier, reducing the risks of suicide and suicide attempts, and limiting the impact of iatrogenic benzodiazepine abuse, besides

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improving their relationships with the health care staff and prison guards.

The chief finding that emerges from even a rapid survey of what is happening in Italian jails is that, apart from generally improved living conditions for prisoners, only a small proportion of patients are able to take advantage of adequate opioid agonist treatments. By contrast, most prisoners are 'mal-treated' with psychoactive drugs, above all benzodiazepines, with the inevitable result that polyabuse phenomena are widespread. Unfortunately, health care staff who work in jails impose rules that differ from jail to jail in applying procedures that are valid only in a given setting; as a result, in almost half of all Italian prisons, whether due to prejudices or to what have come to be considered internal rules, opioid agonist treatments are not made available or, at most, treatments possessing recognized values are scaled down to a degree that makes them unsuitable tools for handling drug addiction. It is worth remembering that rules that are fully valid clearly indicate that responsibility for treatment belongs exclusively to qualified doctors, so that any internal regulations that are applied locally in single prisons are without any legal foundation.

Decree DL 230/99 has laid it down that, in its first phase of application, procedures are to be tried out in full detail in three regions, including Tuscany, which has arranged to immediately implement that law through the appropriate regional authorities, so as to give a complete and exhaustive response to what is required.

From this decree the parts relevant to the inmates of Criminal Mental Hospitals, were, however, removed before the text became definitive, meaning that these prisoners were, in practice, being discriminated against, compared with the general prison population. Luckily, starting in 1997, Local Health Authority of Empoli had been working to set up a convention <sup>(5)</sup>, then an agreement protocol <sup>(6)</sup> and, at a more advanced stage, which became operative in 2000, a joint project with the Criminal Mental Hospital in Montelupo Fiorentino <sup>(7)</sup>, in response to the need to intervene in a more pragmatic way on this type of problem. In addition, through the Drug Addiction Treatment Service in Empoli, where I was working in that period, financial resources which had by then been made available were dedicated to the range of activities sanctioned by DL 230/99.

To enter more directly now into the central topic at issue, in that same period I received an assignment to personally assist all the patients who had problems with drug addiction and who were, from time to time, sent to the Criminal Mental Hospital of Montelupo Fiorentino, by providing them with a substitution treatment, allowing them to be evaluated during their period of stay in the structure and permitting them to keep in touch with the public structures responsible for the territory. During that period, thanks especially to the cooperation set up with colleagues at the Criminal Mental Hospital, drug-addicted patients who had no substitution therapy at the moment of entry, but whose strong psychopathological component was being highlighted — a component marked by self- and hetero-directed aggressiveness, violence, lack of control over impulsive behaviour, unsettled mood with a clearly hypophoric connotation and extreme psychomotor agitation — came to my attention and had to be attended to. The self-aggressive acts presented by these patients took the form not only of self-

inflicted cuts to the upper limbs and the trunk — these being acts that are commonly observed in the general prison population — but also of more life-threatening acts, such as ingestion of alkaline batteries and razor blades, which brought with them the most serious consequences. It should be mentioned that cases like these were exceedingly difficult to manage, compared with patients who had similar characteristics, but who did not have the additional complication of the co-presence of these basic tendencies with a substances abuse disorder — in this context, of heroin.

In fact, the former patients were treated and, from a psychopharmacological point of view, stabilized in an adequate way by the psychiatrists in the structure, whereas in the latter had by then become the paradigmatic cases of Dual Diagnosis. These latter patients had received a simultaneous diagnosis of a psychiatric disorder of axis I in reference to DSM IV-TR, and a substance abuse disorder; satisfactory pharmacological results could not be attained with them, even when all the pharmacologically recognized therapies were tried.

In these cases, then, my advise was requested on how an attempt could be made to manage situations that were in danger of becoming ungovernable and my proposal, on the evidence of the psychopathological characteristics then displayed by those patients, was not to prescribe a number of symptomatic pharmacological substances, but to directly address what I considered to be the focal point in syndromic pictures of this type — what is referred to as the syndrome of secondary abstinence or reflected abstinence or even post-abstinencial abstinence, a syndrome that can appear after a considerable interval from the latest consumption of an opiate. Even if these syndromes can be found in pure heroin addicts, they appear in greatly amplified form in patients with Dual Diagnosis, due to mutual exacerbation between the psychiatric disorder and the substances abuse disorder, and to the creation of 'reverberating circuits' between the two disorders, which have proved to be impossible to interrupt. For the reasons outlined here I began with a small number of patients, since fortunately only a few cases with the characteristics that have been cited reached the Criminal Mental Hospital, to introduce a substitution therapy with methadone, following the customary procedure that comprises the three different phases of induction, stabilization and maintenance, with the final objective of restoring a stable opioid metabolism. The results suddenly took on their own importance, in the sense that the behaviour of these patients underwent a radical change. The main fact that emerged from this experience — an experience that could not fail to bring in mind many of the findings first observed in the early Sixties by Vincent Dole (who passed away quite recently, but whose whole attitude to life convinces us that doctors should not feel like isolated individuals, but part of an indispensable social effort), when he began treating drug-addicted prisoners in New York City — was the changed attitude of those patients. It is true that those patients of mine continued to be difficult, despite the massive psychopharmacological inputs they were still subject to, but they quickly became treatable, so that they were now able to chip in with their own comments in a serene way, without making any more repetitive demands, or — with the main aim of receiving further visits — asking for still more drugs to be added to

their treatment, in an attempt to alleviate the anxiety and agitation which they had, in fact, been prey to until a few days earlier. It is clear enough that a blockade of the opiate system had induced those behavioural modifications, making one suppose that the *primum movens* of the dramatic syndromic picture manifested by those patients lay not so much in the psychiatric component involved, as in the exasperation of their craving for the opiates. It must be added that, from a quick search carried out in the other Italian Criminal Mental Hospitals, this was the first time that a treatment of this type had been implemented in a criminal mental hospital; it should be added that even in ordinary prisons in Italy it is still often a bad habit to put into effect treatments that taper opiate agonists. By contrast, on this particular occasion the health system thought it appropriate, in agreement with the penitentiary health system of that Criminal Mental Hospital, to go ahead with methadone treatments that continued into the maintenance phase, by means of an adequate increase in the dosage of patients who had entered the structure with methadone at an inadequate dosage level; this was done to compensate them from a psychopathological point of view, while the new, adequate dosages were maintained without any fixed time limits. All this was decided from the perspective of improving the quality of life of these persons, while operating on scientific ground and in conscience, with a full knowledge of the twofold point of weaknesses present in each of these subjects.

So, to return now to the focal point of the experience that was built up in the course of those years of collaboration with the Criminal Mental Hospital of Montelupo Fiorentino, this type of treatment was implemented methodically in the case of 23 patients. This statement does not take into account all the other patients who were contacted in the structure, but only at the level of observation, because their stay was more limited in duration. For them that type of treatment was not a real option, partly because, generally speaking, they had no intention of continuing their methadone treatments into the maintenance phase.

Of these 23 patients who experienced the full course of treatment, six, at its inception, were receiving no substitution treatment, which helps to explain the psychopathological characteristics mentioned above — characteristics which led to their being included in a methadone maintenance treatment in the first place. Fifteen other patients had not been receiving an adequate methadone dosage in their treatment, because in the structures they had been transferred from, their doses had been progressively reduced and for that reason that had obviously not had a good outcome, since those patients had first become ungovernable in a common jail structure. The two remaining patients had reached the Criminal Mental Hospital from the Psychiatric Hospitals that were responsible for them, and their evaluation was being followed by the substance abuse services that had originally taken charge of them.

I want to conclude this letter by directing my thoughts to these doubly ill-fated subjects, who have motivated me to continue along this line of participation, which is not intended to be dogmatic, but only to be grounded on scientific evidence. My main hope is that, now a considerable time has passed, someone if not all of those patients

have returned to their places of origin, where I hope that they may have had the opportunity of receiving treatment, that is, clinically speaking, of the same way, mainly in their own interest.

**Italian Legislative references:**

- 1) Legislative Decree No. 230/99
- 2) Legislative Decree No. 49/06
- 3) Presidential Decree 309/90
- 4) Circular Letter dated 22nd May 1998, issued by the General Manager of the Department of the Penitentiary Administration.
- 5) Convention dated 31st December 1997, stipulated between the Ministry of Justice, Regional Branch Office, Criminal Mental Hospital of Montelupo Fiorentino and Empoli Local Health Authority for the treatment of prisoners who are drug and alcohol addicts, still serving their sentences .
- 6) Protocol of understanding dated 31st August 1998 between the Criminal Mental Hospital of Montelupo Fiorentino and the Drug Addiction Service of Empoli's Local Health Authority for the management of patients who are admitted to treatment with methadone.
- 7) Operative project dated 4th May 2000 for the Montelupo Fiorentino Criminal Mental Hospital, by the Drug Addiction Service of Empoli.

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