



Pacini Editore & AU CNS

Editorial

Heroin Addict Relat Clin Probl 2009; 11(3): 5-10

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Methadone Treatment in Italy in the Third Millennium: Continuing Fear of Treatment

Icro Maremmani

¹ Vincent P. Dole Dual Diagnosis Group, Santa Chiara University Hospital, Department of Psychiatry, NPB, University of Pisa, Italy

² AU-CNS, "From Science to Public Policy" Association, Pietrasanta, Lucca, Italy

³ Institute of Behavioural Sciences "G. De Lisio", Pisa, Italy

In Italy, in the third millennium, longstanding mistakes, together with newly emerging, mistaken attitudes, continue to block the objective of making clinical practice adhere to scientific standards, thus preventing healthcare standards from reaching higher levels of quality. Moreover, the authorities seem to be blind to the correspondence between the scientific adequacy of interventions and the consequent degree of control over addiction-related phenomena, such as drug-related crime, the spreading of infectious diseases, jail overcrowding and the social costs of crime repression and rehabilitation.

The prevalent attitude towards drug addiction, supported by unfounded psychological and psychiatric interpretations, is that addiction is a flexible state attributable to the lack of some balancing function, vaguely related to affective soundness and mood reactivity. Most people still take the view that addicts cannot help using drugs because of their need to avoid withdrawal, rather than the other way round [6], and that detoxification is therefore the best kind of intervention that medicine can offer to drug addicts. Relapsing into drug use is not interpreted as a core symptom of addiction, but as a feature of an addictive personality, which can, in any case, be handled by environmental and educational guidance. Each relapse is attributed to contextual factors, and mood swings in affective balance, instead of being read as episodes in

a single disease, separated by clinically silent intervals [7]. Wherever there is the capability of interrupting the drug-using habit for some time, that is mistaken for remission, even if the data show that transient abstinence is the general rule in the history of addiction [16].

Most textbooks that deal with addictive diseases still discriminate – moving clumsily on conceptual grounds – between physical and psychical dependence, viewing cocaine addiction as 'atypical' with respect to the model developed for narcotics, on the grounds that it is characterized by a prominent psychical dependence, while failing to recognize the primary psychopathological nature of craving and relapsing behaviour. Those authors totally omit any mention of the existence of an anticraving approach to drug addiction, and talk of therapeutic opiate agonists as a substitution treatment to be resorted to as a safer form of replacement during a detoxification phase which, they recommend, should last the shortest time possible. These viewpoints are easy to argue against [11]. It can hardly be denied that addiction belongs to the category of substance use disorders, but what is missing is the concept of addictive diseases as induced by chronic exposure to reinforcing stimulation, regardless of subjective effects, through a direct dependence on sub-cortical neurochemical pathways [14, 15].

The spontaneous chronicity of addiction is denied,

Correspondence: Icro Maremmani, MD; "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 0584 790073 Fax +39 0584 72081, E-Mail: maremman@med.unipi.it

leaving no margin of doubt, together with the essential nature of craving as an overactive impulse towards reinforcing stimuli. Chronicity, as also automatic relapsing, are thought of as signs of greater severity, or toxicophilia, and automatically coupled with a negative prognostic perspective. For such addicts, standard maintenance programmes are admitted, though they are presented as harm reduction, and applied in a way that includes the malpractice of ineffective dosing and premature withdrawal of medications.

In Italy, throughout the eighties, the assumed gold standard was to expect and stick to unrealistic outcomes, such as a spontaneous remission due to a variety of unpredictable factors, which were vaguely located in the educational or psychosocial sphere. In that period, no differentiation was made between criminal users, socially impaired subjects and addicts; this lack of clarity has made it far more difficult to interpret outcomes in terms of empirical interventions. Later on, the level of scientific adequacy of treatments improved randomly, the general trend still mirroring the faulty conviction that addiction is sometimes a metabolic disorder, and that, in a metabolic stage, the right approach was to aim for harm reduction. By adopting that mistaken perspective, methadone maintenance was relocated within the cauldron of harm reduction: this shift made it possible to retrospectively justify therapeutic malpractice and the chronic use of ineffective dosages by claiming that methadone treatment is unable to provide any satisfactory outcome for the average drug addict.

Of all therapeutic programmes for drug addiction, methadone accounted for 45-50% in the 1997-2005 period; only 24-31% of all patients on methadone were receiving longer term treatment (> 6 months). In the 2000-2005 period, a trend gradually developed in favour of longer-term methadone administration (> 6 months), but one third of methadone programmes were still planned as short or medium-term [13].

In 2000, over 80% of Italian addicts were still being treated at an average dose below the 60 mg/day threshold of effectiveness: that figure was not attributable to the short term of observation, but tended to stay that low after months of treatment, regardless of clinical response [20].

In a study comparing the features of treatment-seeking addicts in my specialized university treatment unit, I noted that recent admissions corresponded to patients starting treatment at a younger age, but with a longer history of treatment failures. Surprisingly, methadone maintenance at effective dosages had not been tried in most cases before our evaluation [17]. In other words, despite a trend towards early intervention on substance-abusers, no trend has developed towards the enrolment of patients into methadone maintenance treatment programmes as early as possible, using standard blocking dosages. Analysing the clinical and therapeutic history of

enrolled patients, only a small minority could actually be labelled as "treatment resistant", and rates of response to standard treatment have not changed through the years: against our own expectations, there was no trend for severe addicts to concentrate on second-level programmes, which means that the long-term revolving door stage of the average addict corresponds to a milder biological stage of their disease. A positive aspect can be recognized in the evidence that treatment starts earlier; a negative aspect surely consists in the omission of effective treatments for subjects who would be "full responders", because they are affected by a milder form of the disease.

A structured survey about opinions on drug addiction and related issues showed that the level of knowledge has stayed low throughout the 1995-2005 decade, both among patients and the general population [19]. Regardless of the therapeutic setting, patients tend to share with healthy people the misconceptions that addiction is a multi-factorial condition with side medical symptoms deriving from intoxication and withdrawal, that it can heal in a favourable environment due to one's strength of will, and that residential treatment is the key intervention in achieving long-term stability.

Detoxification interventions have never been limited to functioning as the induction phase of antagonist programmes, for selected patients, and are still performed as standalone therapies, possibly returning the addict to his/her original environment with an increased risk of overdosing due to the loss of tolerance [9, 18, 21].

Almost any critical life event (imprisonment, pregnancy, hospitalization) is handled as an opportunity to achieve and maintain spontaneous abstinence, or taper medications, instead of becoming an opportunity to initiate or stabilize treatment. People seem to be in search of increasingly rapid methods for tolerance reversal, which are promoted as 'detoxification'.

The impact of the newer resource against heroin addiction, buprenorphine, adds another point of view in clarifying the therapeutic trends in Italian public services. In the 2001-2005 period, buprenorphine treatment did spread all over Italy: nevertheless, its use has often been that of providing a smoother form of detoxification (58.4% in 2001, 36% in 2005), whereas buprenorphine maintenance (> 6 months) was the treatment adopted in 41.6% of these cases in 2001, a figure that rose to 63.9 in 2005. Surprisingly, in 2005 the rates of buprenorphine treatments with respect to all treatment programmes had jumped from 3.8% in 2001 to 15.3%, but in some regions values had risen above 25% [13]. Actually, it is likely that a subpopulation of addicts was shifted onto buprenorphine programmes although stabilization on methadone had already been achieved, the aim being to favour tapering and the withdrawal of any opiate treatment more comfortably than is thought to be possible with methadone.

In a 1997 study [9] conducted to ascertain the causes

of heroin overdosing, authors found that just one subject out of four was tolerant to opiates at times of acute intoxication, whereas 65.5% were not tolerant due to the detoxification they had undergone; 7.3% were receiving lower methadone doses (below 40 mg/die) than before because they were no longer in prison or protected environments. Although methadone maintenance at doses higher than 40 mg/die would seem to be protective (no case recorded), recent dropping out of methadone maintenance was the least likely status of overdosing addicts, followed by recent abandonment of naltrexone maintenance (1.8%). In other words, the vast majority of overdosing addicts, instead of being just chronically intoxicated, had been driven to a condition of enhanced risk due to an increased craving/tolerance ratio.

Another surprising corpus of data about overdoses, in Italy, reveals that the mean age of those who are overdosing has increased through the years 1996-2005, from 30-31 to 34-35 years old [13]. As a trend, it is not new, younger addicts who run the risk of overdosing before entering treatments, but those who started their first treatment programmes years before, which can only mean that the standard handling of drug addicts in the therapeutic web offers poor protection against overdosing. The likelihood of overdosing just seems to be postponed to an older age bracket, suggesting that treatment programmes only provide transient protection against the consequences of addictive drug use.

On the whole, knowledge that methadone maintenance provides protection against overdoses [1-4, 12, 22], and other causes of addiction-related death seems to be ignored on grounds of clinical practice, although studies of this type have been performed on the Italian population [5, 10].

The evolution of knowledge in the field of therapy and the neurosciences has not been translated into the empowerment of interventions, in terms of outcome and the correction of chronicity. Psychiatry's newborn interest in addictive diseases has been polluted by the confusion between drug use and addiction dynamics, the latter being implicitly regarded as a phenomenon secondary to more 'classical' psychiatric disorders. Attempts to challenge addiction by antidepressant treatment have resulted in the demonstration of the short-term effectiveness of almost any medication, but with two major limitations: the meaninglessness of short-term changes in a chronic relapsing disorder, and the employment of generic psychopathological endpoints, which simply confirm that some drugs are toxic, and that medically assisted detoxification provides patients with transient alleviation of their discomfort.

A further problem is that psychologists tend to elude the grounds of scientific measurement and found their practice on suggestions from case reports. Actually, the feasibility of psychotherapeutic approaches for drug addicts derives from the capability to interpret individual cases consistently with pertinent theoretical models.

Against those who could object that no standardized treatment can be thought of in this way, and that interventions cannot even be planned, those practitioners are able to answer by referring to the concept of treatment tailored to the individual. Most psychologists and community operators are highly critical of any concept of treatment standardization that relies on shared, measurable core symptoms of addiction: to them, standard dosing, duration and regimens are unwelcome as the basis for individual tailoring to psychosocial and psychological needs, but are treated as the neglect of differences between individuals. Dividing addicts into categories in order to identify programmes that are modelled on the needs of subgroups is seen as caging people into dead-end situations by applying artificial labels. Paradoxically, they argue that environmental and personal differences are a reason for not working on addiction-related similarities between affected individuals. Those who oppose statistically founded treatment still wave the flag that "Each case is a case unto itself", so showing their failure to understand that tailoring has to come second to stabilization in a hierarchical order.

Their viewpoint is that the more a drug ties the patient to a longer-term regimen, the less it can be considered to favour progress towards remission: pharmacological dependence is read by them as a feature that is shared between addiction and therapy, and is thus counterproductive to any perspective of healing. The underlying opinion is that dependence on a therapy is not therapeutic, but generates chronicity: on the contrary, a crucial basis of the effectiveness of agonist maintenance is the establishment and maintenance of a state of tolerance, at an even higher level than that induced by chronic exposure to heroin. As a result, physical dependence on the therapeutic drug is not a limitation in an agonist treatment programme, but a key for it to be fully effective: the treatment of addiction through to remission requires the patient to undergo a period at a heightened level of dependence, because only this ensures an opiate blockade and higher rates of retention in treatment, while partly overcoming the problems of lower or transient compliance [8].

Previously, the stigma against methadone patients seemed to be closely related to an extended prohibition, which was blind to the differences between illegal substances and therapeutic medications, and fond of a self-administered, drug-free solution. However, it has become clear that many of those who defended medications, did so by applying a kind of reverse prohibition, arising from the thought that substances, whether legal or illegal, can become addictive due to their special status. On such a view, controlled heroin administration is preferable to methadone maintenance, and no actual difference is recognized between therapeutic opiates and toxic ones. The common ground of these two equally misleading conceptions, is the denial that addiction is a brain disease. In both conceptions, addiction is just a problematic form of drug use, and nothing more: in the

former it depends on individual deficiencies, in the latter on environmental factors. Moreover, addiction is supposed to stay flexible and reversible, so that the changes in the factors that influence the way people resort to drugs are thought to be crucial in turning addiction back into controlled drug use, or in turning it into lighter drug use. Resorting to maintenance treatments is regarded as a renounce to healing.

Evidence that healing without medical treatment is quite improbable will not change the views of those for whom the way in which healing should be is more important than the real likelihood of healing. One emblematic statement is that of an Italian therapeutic community director, who said that “some actually stop” after community treatment. As long as public opinion prefers a few isolated healings to a multitude of stabilized patients, recovery from this disease may just come about by chance, in cases of non-treatment. Scientific knowledge will continue to have little impact, as long as cases of successful treatment are read as failures by the dominant culture in Italy.

Unfortunately, it may be that this is not an exclusively Italian problem.

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Conflict of Interest

No conflict of interest to report.

Role of funding source

No funds.

Received and Accepted May 30, 2009

