RABA, ZLORABA IN ODVISNOST OD PSIHOAKTIVNIH SNOVI

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Uvodnik

Odvisnost narašča po vsem svetu, toda narašča tudi razumevanje tega pojava in večajo se resnične možnosti za ozdravitev in preprečevanje (1).

O drogah - ali so res nevarne

Psihoaktivne snovi (PAS), v slovenščini jim pravimo tudi droge, so sestavni del človekove zgodovine in sedanjosti. Njihova uporaba je vedno povezana s posameznikovo željo po spremembi trenutnega čustvovanja, doživljanja in vedenja. Nekatere droge se nahajajo v naravi, druge je treba predelati iz naravnih virov, tretje so proizvod bolj ali manj zapletenih kemijskih procesov. Zato je PAS težko ustrezno razdeliti v določene skupine. V medicini uveljavljena razdelitev PAS je nekakšen kompromis med sestavo (alkohol, nikotin, kofein, opioidi) in učinki teh snovi (sedativi, hipnotiki, halucinogeni) (2). Za uživanje PAS so si posamezne kulture izoblikovale določena pravila in rituale, s katerimi so določile, katerim članom je dovoljeno uživati določeno PAS in ob katerih priložnostih, pa tudi to, katerih PAS ni dovoljeno uživati. Iz tega izhaja razdelitev na dovoljene (legalne) in nedovoljene (ilegalne), nekateri govorijo tudi o »pollegalnih« PAS - ko se sicer legalne PAS (na primer uspavala) pridobivajo in uporabljajo na nedovoljene načine. Delitev na t. i. mehke in trde droge je nesmiselna, saj ne označuje niti sestave niti učinkov niti statusa (dovoljena - nedovoljena) PAS.

Za PAS je značilnih več tipičnih vzorcev uživanja. Tako govorimo o rabi, zlorabi in odvisnosti od PAS, pri čemer so posamezni vzorci bolj ali manj natančno opredeljeni. Še najbolj natančni so v primeru alkohola, kjer so tudi količinsko opisani. Upoštevaje starost in spol možnega uživalca govorimo o manj tvegani in tvegani rabi (pitju), o akutni zastrupitvi, škodljivem pitju in o odvisnosti od alkohola (3). Pri drugih PAS so opredelitve bolj splošne, pri čemer je za določitev sindroma odvisnosti treba upoštevati v klasifikaciji določena merila: močno željo po zaužitju droge, težave pri obvladovanju jemanja droge, vztrajanje pri uživanju droge kljub škodljivim posledicam, večje posvečanje uživanju droge kot drugim dejavnostim in obveznostim, povečano toleranco in včasih telesne motnje zaradi odtegnitve snovi (2).

Ugotovili so, da imajo posamezne PAS različni potencial za nastanek odvisnosti. Največjega ima nikotin, saj bo od njega postalo odvisnih kar 32% kadilcev, sledijo heroin (23%), kokain (17%), alkohol (15%), stimulansi (brez kokaina, 11%), kanabis, analgetiki, anksiolitiki, sedativi in hipnotiki (9%), halucinogeni (5%) in inhalanti (4%) (4, 5).

Mnenja o nevarnosti posameznih PAS so zelo različna, saj je za določitev pojma nevarnosti potrebno navesti merila. Tako velja nikotin za sorazmerno nenevarno drogo, čeprav povzroča daleč največ zdravstvenih problemov. V Veliki Britaniji so to spoznali in z zakonom uredili zdravljenje odvisnosti od nikotina (6), in s tem v nekaj letih dosegli zavidljive rezultate. V Sloveniji smo šele na začetku izvajanja programov za opuščanje kajenja, žal pa na negativni listi ostaja edino zdravilo (bupropionum), ki je dokazano učinkovito. Tudi splošno mnenje o alkoholu, ki ga uživa velika večina odraslih prebivalcev Slovenije, je podobno - da gre za nenevarno drogo, čeprav zaradi posledic uživanja alkohola vsako leto umre veliko ljudi (7). Še vedno je razširjeno prepričanje o nenevarnosti marihuane, vendar je nedavno objavljena študija dokazala, da je akutna raba marihuane statistično pomembno povezana s poškodbami v prometnih nesrečah (8). V nekaterih državah se že zavedajo nevarnosti zlorabe zdravil s psihotropnim učinkom, zato načrtujejo in izvajajo ukrepe za zajezitev tega problema (9).

Vedno bliže smo odgovoru na vprašanje, zakaj so PAS tako privlačne. Ugotovljeno je, da stres povečuje tveganje za razvoj odvisnosti (10), zato znova pridobiva na pomenu model »samopomoči« (jemanje PAS z namenom sproščanja napetosti), ki odvisniško vedenje obravnava kot posebno obliko učenja. Pri tem igrajo pomembno vlogo geni, ki določajo med drugim, ali bo raba PAS za posameznika prijetna, kako intenzivni bodo njeni učinki in kako hitro se bodo pokazali škodljivi učinki ter kolikšna je verjetnost, da se bo razvila odvisnost (11).

V novejšem času nekateri govorijo tudi o nekemičnih odvisnostih, s čimer želijo označiti odvisniško vedenje, ki ni vezano na določeno PAS, temveč gre za motnje v obvladovanju impulzov, na primer na področju iger na srečo, nakupovanja, hranjenja in spolnosti. Ugotovljeno

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je, da se te motnje pogosteje pojavljajo pri ljudeh, ki so odvisni od PAS, pa tudi to, da je zdravljenje mogoče izvajati po podobnih načelih.

Preventivni programi - zakaj niso bolj učinkoviti

Za javno zdravstvo so pomembne predvsem tiste škodljive posledice uživanja PAS, ki jih lahko ugotavljamo na populacijski ravni. Zanimivo je, da se zahodne države praviloma raje ukvarjajo s prepovedanimi drogami in za programe, namenjene zdravljenju in preprečevanju odvisnosti od njih namenjajo bistveno več sredstev kot za dovoljene droge. Stroškovno najbolj učinkoviti preventivni ukrepi, kot so obdavčenje, omejen dostop in zmanjšanje promocije, so nepriljubljeni in se jih politika izogiba (12). Tudi v Sloveniji je situacija podobna. Zdaj že imamo podatke o tem, da imata alkohol in nikotin veliko večjo težo zdravstvenih in socialnih posledic kot nedovoljene droge, a kljub temu politika ne kaže večjega interesa za učinkovito ukrepanje. Predloge o tem, kako naj bi se lotili zmanjševanje škode zaradi prekomerno zaužitega alkohola, je že pred 170 leti objavil Fran V. Lipič (13), neverjetno podobne so tudi sodobne ugotovitve (14). Raziskovanje škodljivih posledic rabe alkohola v Sloveniji je že dalo nekaj zanimivih podatkov (7, 15), ki kličejo po oblikovanju in doslednem izvajanju alkoholne politike na nacionalni ravni (16). Epidemiološke raziskave, ki so bile v Sloveniji opravljene doslej, so primerljive le za starostno skupino mladostnikov v 1. letnikih srednjih šol (17), najslabše obdelana pa je starostna skupina mlajših odraslih (do 25 let starosti), ki bi morali postati ciljna populacija preventivnih programov za odraslo populacijo.

Kako naj bi se pripravljala in izvajala preventiva, s katero bi lahko dosegli zmanjšanje zlorabe in zdravstvenih ter socialnih posledic rabe PAS? V splošnem velja, da naj bi se zmanjšali tako ponudba kot povpraševanje po drogah. Ker vemo, da se obdobja povečane oziroma zmanjšane stopnje zlorabe PAS izmenjujejo, je s preventivnimi ukrepi smiselno modificirati ugotovljene trende (18). Prepričanje, da je smiselna le primarna preventiva (ukrepi pred začetkom simptomov), je zamenjalo spoznanje o potrebnosti različnih ravni preventivnih dejavnosti, saj so s PAS povezane motnje kronične in podvržene ponovitvam. Tako so se kot posebej učinkovito izkazali po eni strani t. i. zgodnji ukrepi, predvsem v okviru osnovnega zdravstva (19), po drugi strani pa programi za preprečevanje recidivov (20). NIDA (The US National Institute of Drug Abuse) je na podlagi dolgoletnih raziskav razvila seznam osnovnih načel za preventivne dejavnosti: Preventivni programi morajo povečavati zaščitne dejavnike in zmanjševati dejavnike tveganja. Ti dejavniki različno vplivajo na posamezne skupine prebivalstva, zato morajo upoštevati starost, spol, narodnost, kulturo in okolje ciljne skupine oziroma posameznika. Preventivni programi morajo biti pripravljeni tako, da se nanašajo na specifične dejavnike tveganja za določeno populacijo in se izvajati v daljšem obdobju z načrtovanimi ponovitvami, ki naj okrepijo načrtovane cilje (21). Kljub navidezno jasnim in uspešnim preventivnim programom, pa se poraba PAS povečuje, zato se mnogi znanstveniki sprašujejo, kaj je narobe (12), in ugotavljajo, da se enostavno prenašanje preventivnih programov iz enega kulturnega okolja v drugo ne obnese. A tudi uspehi preventivnega dela, doseženi na področju zmanjševanja kajenja, imajo drugo plat: tobačna industrija je svojo dejavnost prenesla v manj razvita okolja.

Nekateri vidiki zdravljenja - kaj bi lahko izboljšali

Diagnostika

Osnovno vprašanje je, na kateri ravni zdravstvenega sistema naj bi se opravljala diagnostika motenj, povezanih z rabo PAS. Zdravniki v osnovnem zdravstvu naj bi bili dovolj usposobljeni za ugotavljanje teh motenj, vendar se srečujejo s številnimi težavami, ki diagnostiko otežujejo (22). V pomoč so jim lahko ustrezni in uporabni pripomočki (3). Dogaja se, da specialisti določene motnje, povezane z jemanjem PAS, spregledajo (23) ali pa izbrani zdravniki od njih (npr. od specialista psihiatrije) zaradi narave delovanja zdravstvenega sistema ne dobijo ustreznih informacij. Tako se izgublja čas, ko bi bilo z ustrezno diagnozo bolnika mogoče motivirati za opustitev PAS ali ga napotiti na zdravljenje odvisnosti ter tako zmanjšati zdravstvene in socialne posledice.

Abstinenca

Prepričanje o nujnosti abstinence kot pogoju za zdravljenje odvisnosti od alkohola med slovenskimi strokovnjaki nikoli ni bilo sporno, čeprav so se mnenja v tujini večkrat spreminjala (24). Zadnje ugotovitve dolgoletnega spremljanja alkoholikov po zdravljenju kažejo, da se po 16 letih zdravljenci ustalijo v enem od dveh vzorcev, tj. v abstinenci ali v neizboljšanem pivskem vedenju (25). T. i. kontrolirano pitje pri zdravljencih je sicer možno, a vedno časovno omejeno (lahko tudi več let) in se v daljšem obdobju ne more

obdržati - zdravljenci recidivirajo ali ponovno vzpostavijo abstinenco. Delež tistih, ki ohranijo trajno abstinenco po prvem zdravljenju, je sorazmerno majhen (do 20%), a se skupni delež tistih, ki jih spremljamo po indeksnem zdravljenjem, po vsakem ponovnem zdravljenju veča in doseže približno 40%. Takšen rezultat pa je enak ali boljši kot pri zdravljenju nekaterih drugih kroničnih bolezni (26).

Čeprav je znano, da so mehanizmi za nastanek odvisnosti od psihoaktivnih snovi podobni in se različne odvisnosti med seboj prekrivajo, pa zdravljenje drugih vrst odvisnosti ne temelji vedno na abstinenci. Celo nasprotno, zdravljenje poteka z vzdrževanjem določene stopnje intoksiciranosti odvisnega, kar je značilno za vzdrževalni metadonski program. O smiselnosti in učinkovitosti takšnega pristopa je na voljo ogromno literature, ki večidel podpira vzdrževalni metadonski program, obstajajo pa tudi vedno bolj utemeljeni ugovori (27). Tudi med strokovnjaki zelo razširjeno mnenje, da je odvisnim od opioidov treba čimprej in dovolj izdatno pomagati z metadonom, ima svoje nasprotnike. Ti so prepričani, da so v abstinenco usmerjeni programi strokovno in etično bolj primerna oblika obravnave, ki pa zahteva več časa in znanja, večje število strokovnjakov in ustanov.

Recidiv

Preprečevanje recidiva je eden ključnih postopkov v zdravljenju odvisnosti, saj so recidivi ena od značilnosti te motnje. Podobno kot se dogaja bolnikom, ki se zdravijo zaradi astme ali hipertenzije, tudi pri odvisnih prihaja do občasnih poslabšanj oziroma recidivov bolezni. V primeru somatskih bolezni so takšna nihanja povsem sprejemljiva, pri odvisnosti pa mnogi bijejo plat zvona. Pojav recidiva v procesu zdravljenja odvisnosti je dobro preučen. Ugotovljeno je, da obstajajo tri vrste dejavnikov, ki povečujejo hrepenenje po drogi in s tem vodijo do recidiva.

To so:

1. »preskušanje« s samo enim požirkom ali dimom, ki lahko sproži hitro ponovitev vseh znakov odvisnosti;
2. »namigi« v obliki krajev, ljudi ali situacij, povezanih z jemanjem določene droge in;
3. kratkotrajni ali dolgotrajni stres.

V programih za preprečevanje in obvladovanje recidiva bolnike naučijo prepoznavati in obvladovati omenjene dejavnike (20), kot koristno dopolnilo pa uporabljajo tudi nekatera zdravila (disulfiram, naltrekson).

Podaljšano oziroma nadaljevalno zdravljenje (after-care)

Odvisnost ima vse znake kroničnih bolezni, zato je pri načrtovanju zdravljenja to dejstvo treba upoštevati in bolnikom omogočiti, da so v proces zdravljenja vključeni dovolj časa in na zanje sprejemljiv način.

Zdravljenje odvisnosti od alkohola v Sloveniji poteka v treh, med seboj povezanih stopnjah (28), ki zagotavljajo celostno in dovolj dolgo trajajočo skrb za osebe, odvisne od alkohola, in njihove družine. Poseben pomen imajo vse oblike podaljšanega zdravljenja, ki zdravljencem omogočajo postopno spreminjanje življenjskih navad in okolja. Pomembno je, da delujejo čim bliže kraju stalnega bivališča ter nimajo posebnih vstopnih meril, ki bi zdravljence odvračale od vključitve. V Sloveniji so poznani »klubi zdravljenih alkoholikov« (nekateri imajo že 40-letno tradicijo), v zadnjem desetletju jim po množičnosti sledijo skupine »Anonimnih alkoholikov.« Slednji sicer niso del zdravstvenega sistema, vendar se z njim dobro dopolnjujejo.

Zdravljenje odvisnosti od nedovoljenih drog v Sloveniji poteka drugače in je organizirano v mreži ambulantnih centrov (29) in enem hospitalnem oddelku (30), nima pa razvite tretje stopnje oz. nadaljevalnega zdravljenja, kamor bi se lahko vključevali zdravljenci in njihovi svojci po končanem intenzivnem zdravljenju. Vrzel deloma premoščajo nekatere nevladne organizacije, ki pa ne morejo v celoti prevzemati vloge nadaljevalne faze zdravljenja, ki se začenja v okviru zdravstvenega sistema.

Programi za zdravljenje motenj v nadzoru impulzov (odvisniškega vedenja)

Glede na prevalenco in težo teh motenj je najbolj pomembno patološko hazardiranje, ki je za posameznega bolnika in njegovo družino lahko veliko bolj usodno kot odvisnost od določene psihoaktivne snovi. Ker se je igralništvo razvilo tudi v Sloveniji, narašča tudi potreba po organiziranju in izvajanju strokovne pomoči za patološke hazarderje. Ne glede na našo zapletenost postopkov za uvajanje novih zdravstvenih programov je dobro poznati izkušnje iz okolij, kjer tovrstne oblike pomoči uspešno uporabljajo (31).

Medicina odvisnosti

Ideja, ki jo predstavlja pojem *medicina odvisnosti*, je v povezovanju različnih medicinskih specialnosti in izvira iz Združenih držav Amerike. Tamkajšnje združenje za medicino odvisnosti (American Society of Addiction Medicine, ASAM) je bilo ustanovljeno leta 1954 in združuje zdravnike, ki se posvečajo izboljševanju zdravljenja alkoholizma* in drugih odvisnosti, izobraževanju zdravnikov in študentov medicine, razvoju raziskovalnega in preventivnega dela ter

*Slovenska doktrina zdravljenja odvisnosti uporablja namesto izraza alkoholizem strokovno ustreznejšo oznako sindrom odvisnosti od alkohola. Slednji je tudi uradna diagnoza po Mednarodni klasifikaciji bolezni. Vendar se izraz alkoholizem v angleškem govornem področju, tako v strokovni literaturi kot v imenih ustanov, ki se ukvarjajo s problematiko odvisnosti od alkohola, še vedno pojavlja. Tudi ASAM v svoji predstavitvi uporablja izraz alkoholizem, zato ga na tem mestu posredujemo v nespremenjeni obliki. Sicer pa o rabi (in zlorabi) izraza alkoholizem med strokovnjaki, jezikoslovci, sociologi in drugimi, ki se s to problematiko srečujejo tako doma kot v svetu, še potekajo razprave.

prosvetljevanju in informiranju medicinske skupnosti in celotne javnosti.

Medicina odvisnosti naj bi združevala zdravnike v naslednjih vejah medicine: splošna in družinska medicina, urgentna medicina, pediatrija, interna, psihiatrija, nevrologija, kirurgija, ginekologija in porodništvo, onkologija ter socialna oziroma preventivna medicina. Seveda so k sodelovanju vabljeni tudi drugi zdravniki in zobozdravniki, ki jih zanima to področje strokovnega delovanja.

Zakaj je takšno sodelovanje pomembno in potrebno? Dejstvo je, da posledice škodljive rabe alkohola in/ali drugih psihoaktivnih snovi prizadenejo človeka kot celostno bitje. Ob pogostih poškodbah, depresivnih in anksioznih stanjih, kroničnem gastritisu, zvišanem krvnem tlaku in številnih drugih boleznih bi vsak zdravnik moral biti pozoren na možnost škodljive rabe alkohola. Podatki o rabi alkohola, nikotina, kofeina, psihofarmakov in prepovedanih drog bi morali postati sestavni del vsake zdravstvene kartoteke. Zdravniki in medicinske sestre bi lahko s pomočjo enostavnih, a zanesljivih testov razlikovali med problematičnimi pivci in tistimi, ki so že odvisni. S kratkimi, a strukturiranimi postopki bi lahko pomembno zmanjšali porabo alkohola v določeni populaciji. Zdravniki, ki želijo na tem področju narediti še več, se lahko naučijo postopkov, s katerimi bolnike motivirajo za spremembe v načinu življenja (abstinenca, opustitev kajenja, drugačen način prehrane ...).

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PSYCHOACTIVE SUBSTANCE USE, ABUSE AND DEPENDENCE

Zdenka Čebašek-Travnik[1]

Editorial

Drug addiction has been increasing world wide, but our understanding of the issue has improved and the possiblities for treatment and prevention have been expanding (1).

Drugs - are they really dangerous?

Psychoactive substances, called also drugs in Slovene, are an integral part of the history and present of the human race. Drug use always reflects one's wish to change the way he/she feels, perceives and behaves. Some drugs are present in the nature, some are products of natural sources, and some are the result of a more or less complex chemical process. Assigning psychoactive substances to different categories is therefore not an easy task. The categorization system adopted in medicine is a kind of compromise between a system based on drug composition (alcohol, nicotine, coffeine, opiates) and one considering the effects of these drugs (tranquillizers, hypnotics, hallucinogens) (2). Different cultures formulated their own rites and rules concerning the use of psychoactive substances; persons allowed to use drugs, occasions on which drug use was allowed and prohibited substances were determined. On these grounds, drugs have been divided into legal and illicit; there are also the so-called »semi-legal« psychoactive drugs, such as sleeping pills, which are legal yet used in an illegal way. The distinction between »soft« and »hard« drugs is a misconception as it does not define their composition, effects or status (legal/illegal).

There are several typical, more or less accurately defined patterns of psychoactive substance use: use, abuse and addiction. Alcohol has been investigated in most detail, even as concerns the impact of the volume of alcohol consumption. Considering the user's age and sex, the use may be defined as riskful drinking, acute intoxication, harmful drinking or alcohol dependence (3). The definition for other psychoactive substances is more general; so the definition of the dependence syndrome is based of the criteria for drug dependence in ICD-10, whcih include: a strong desire to take drugs, difficulty controling drug use, persisting with druge use despite clear evidence of harmful effects, focusing on drugs to the exclusion of other activities and obligations, increased drug tolerance and withdrawal-related physical symptoms (2).

It was found that psychoactive substances differ in their addictive potential. It is highest for nicotine, with 32% of cigarette smokers becoming dependent on tobacco; there follow heroin (23%), cocaine (17%), alcohol (15%), stimulants (excluding cocaine, 11%), cannabis, analgesics, anxiolytics, sedatives and hypnotics (9%), hallucinogens (5%) and inhalants (4%) (4, 5).

There is disagreement concerning the risk of psychoactive substance use, because firm criteria should be established for the definition of risk. So, nicotine is still considered a relatively »unharmful« drug although it causes by far the greatest number of health problems. In Great Britain the risk of tobacco use was recognized and the treatment of nicotine-addicted smokers was legally regulated (6) The results obtained there in the past few years are very promising. In Slovenia, the programme of smoking cessation is still at an early stage. Unfortunately, bupropion, the only drug that has proved effective, is not yet covered under the national health insurance plan. Similarly, alcohol, which is consumed by a great proportion of adult population in Slovenia, is still considered an unharmful drug although the consequences of alcohol abuse kill a considerable number of people every year (7). It is commonly believed that using marihuana is harmless although a recent study has shown a significant correlation between acute use of marihuana and injuries sustained in traffic accidents (8). Some contries, however, have recognized the risks of psychoactive substance abuse, and are planning and taking measures to solve this problem (9).

The commonly asked question of why taking psychoactive substances is so attractive is about to be answered. It has been found that stress increases the risk of drug dependence (10), and interest has been revived in the so-called »self-help« model, which holds that people take psychoactive substances to relieve stress, and regards dependent behaviour as a special way of learning. Genes play a key role here: they determine whether taking psychoactive substances will have pleasurable effects, how intense these effects

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will be, how long harmful effects will take to appear, and predict the probability of dependence development (11).

The concept of non-chemical dependence, which that has been increasingly addressed recently, postulates that dependent behaviour is not restricted to the use of psychoactive substances and that it should be interpreted as an impulse control disorder, manifested as pathological gambling, compulsive shopping, eating and sex. It was found that lack of impulse control occurs more frequently in people addicted to psychoactive substances, and that the treatment of this disorder can follow similar principles.

Preventive programmes - why are they not more effective?

Public health services deal mostly with the population-level harmful consequences of psychoactive substance use. Interestingly, Western countries focus primarily on the problem of illicit drug use and therefore allot considerably larger funds for illicit drug treatment and prevention than for programmes combating legal drug use. The most cost-effective preventive measures, such as taxation, restricted access to drugs, and restrictions on advertising are unpopular and mostly avoided by policy-makers (12). The situation in Slovenia is very similar. Research has shown that the health and social burden of alcohol and tobacco use is significantly greater than that of illicit drugs. There is a striking similarity between the current programmes (14) and suggestions for reducing alcoholism-related harm which were put forward by Fran V. Lipič 170 years ago (13). Interesting data from research on harmful effects of alcohol use in Slovenia (7, 15) call for the formulation and consistent implementation of alcohol policy at the national level (16). Epidemiological studies carried out in Slovenia to date are comparable only for students of the first grade of secondary schools (17). Data are lacking for the group of young adults up to 25 years of age who should be targeted by the preventive programmes for the adult population.

How are preventive activities aimed at reducing psychoactive substance abuse and its health and social consequences planned and carried out? Their main aim is to curb both the supply and demand of drugs. Since periods of increased psychoactive drug abuse alternate with periods of decreased use, it would be most sensible to take measures to modify the established trends (18). The concept stressing the key role of primary prevention was replaced by the belief that preventive activities should be carried out at various levels, because disorders associated with psychoactive substance abuse are chronic and tend to recur. Early interventions at the primary health level (19), as well as programmes preventing relapse to substance abuse (20) have both proved very effective. The US National Institute of Drug Abuse (NIDA) put forward a list of basic preventive strategies, based on the results of many years' research. They maintain that preventive programmes must enhance protective factors and reduce risk factors. Since the effects of these factors vary from one population group to another, the programmes should be tailored to age, sex, nationality and cultural and social background of the target individual or group. Preventive programmes should consider risk factors specific of the target population and should be carried out over a long period of time. In addition, the programmes should be repeated to consolidate the results obtained (21). Despite well-designed and successfully implemented preventive programmes, the prevalence of psychoactive substance use keeps increasing. Some scientists wonder what goes wrong(12 Utenhagen) and some maintain that transplanting preventive programmes from one cultural background to another simply does not work. Also, there is another side to effective tobacco reducing programmes: tobacco industry, discouraged by good results of preventive activities, tends to move to economically less developed countries.

Some aspects of treatment - what improvements can be made?

Diagnosis

The primary question remains: at what level of health care should the diagnosis of psychoactive substance dependence disorders be carried out? Primary care physicians have the special knowledge and skills required to identify these disorders, yet they are confronted with many problems hindering the diagnosis (22). Some useful tools are currently available to help them (3). It may happen that specialists overlook specific problems associated with the use of psychoactive substances (23), or that they (e.g. psychiatrists) fail to supply appropriate information to primary care physicians because of the malfunctioning national health care system. This results in a delay in making the diagnosis and motivating the patient to get off psychoactive drugs, or in a delay in referring him/her for dependence treatment in order to reduce health and social consequences of the disorder.

Abstinence

Despite some conflicting recommendations in the past, the Slovene specialists have always agreed that alcohol-dependent patients must be abstinent at the initiation of treatment (24). The results of long-term follow up of recovering alcoholics showed that at 16 years after treatment they either remain sober or persist with alcohol abuse (25). The so-called controlled drinking is a possible, yet time-limited drinking pattern adopted by some alcoholics. It has been found that a few years after treatment they relapse or regain abstinence. The proportion of patients who achieve permanent abstinence after the first treatment is relatively small (up to 20%), yet the percentage of those followed after treatment based on ASI score, increases after each treatment course to attain approximately 40%. This outcome is equal to or better than that observed in patients treated for some other chronic illnesses (26). Although it is well known that similar mechanisms are responsible for psychoactive substance dependence, and that several dependence disorders may overlap, the treatment of other types of dependence is not always based on abstinence. On the contrary, treatment, e.g. the methadone maintenance programme, may consist of maintaining certain level of intoxication. The rationale and effectiveness of this therapy have been dealt with in many studies, which generally support this therapeutic approach. Yet, some increasingly well-founded arguments against methadone maintenance treatment have been reported by some authors (27). In contrast to the widely accepted view that opiate-dependent patients need immediate and full methadone support, some authors maintain that abstinence-directed programmes are professionally and ethically superior to he former. They acknowledge, however, that they are more demanding in terms of time, knowledge, specialist staffing and facilities required for their implementation.

Relapse

Preventing relapse, which is one of the characteristic traits of dependence disorders, is one of the key goals pursued by treatment. In substance-dependent patients, like in patients treated for asthma or hypertension, occasional deteriorations and remissions may occur. While these events are generally fully acceptable in patients with chronic medical diseases, they are cause of alarm in addicted persons. The phenomenon of relapse in the course of treatment has been investigated in great detail. Three types of triggers which enhance craving with the resulting relapse have been identified.

These include:

1. testing personal control by having a drink or a smoke, which may trigger prompt recurrence of all dependence symptoms,
2. »hints« as to locations, people or situations connected with a specific drug, and
3. short or long-term stress.

Patients included in the relapse prevention programmes learn how to recognize and cope with these triggers (20); in addition, medicines, such as disulfiram and nalrexone, are prescribed as treatment adjuncts of relapse prevention programmes.

Substance treatment aftercare

The fact that substance dependence shows all signs of chronic illnesses should be taken into consideration when designing these progammes. They should be of adequate length and acceptable to patients. Alcoholism treatment programmes in Slovenia consist of three phases (28). They provide comprehensive treatment and continuing aftercare of alcoholics and their families. Special emhpasis is placed on various forms of aftercare which enable the recovering alcoholics to change their behaviours, lifestyles and environment. The programme should be provided near the place of the patient's residence.There should be no admission criteria that would discourage service seeking patients from entering the programme. In Slovenia, patients meet in clubs for recovering alcoholics (some of them functioning for 40 years), or are involved in Alcoholics Anonymous groups. The latter are not part of the national health system, yet they represent an effective complementary self-help approach.

Treatment of illict substance dependence in Slovenia is provided by a network of outpatient centres (29) and one inpatient department (30). After the completion of acute treatment, however, no aftercare programme is available for the recovering addicts and their families. Some non-governmental organisations try to fill the gap, yet they are not able to provide complete aftercare services following treatment provided within the national health system.

Treatments of impulse control disorders

Because of its prevalence and severity, pathological gambling is considered one of the leading impulse control disorders. It is known to have a greater impact on the life of an individual and his/her family and much more devastating consequences than psychoactive substance addiction. With the rapid expansion of gambling in Slovenia a need arose for the provision of professional assistance for pathological gambling problems. Since initiating new health care programmes

in Slovenia is a complicated process, it is very useful to learn more about effective forms of help used in other environments.

Addiction medicine

The idea to establish medicine as a special field integrating different medical specialties was born in the U.S.A. The Americal Society of Addiction Medicine (ASAM), which was founded in 1954, is committed to improving the treatment of alcoholism and other dependence disorders, as well as to the education of physicians and medical undergraduates, research and prevention. In addition, its important task is to inform the medical community and the general public about the complex issue of substance dependence.

Addiction medicine covers the following disciplines: general and family medicine, emergency medicine, paediatrics, internal medicine, psychiatry, neurology, surgery, gynaecology and obstetrics, oncology and social / preventive medicine, yet all other specialists interested in the professional field, including dental surgeons, are encouraged to participate.

Why is this common action so important? In addition to doing harm to the individual, alcoholism and/or other psychoactive substance abuse affect all aspects of his/her life. The possibility of alcohol abuse should always be considered in patients presenting with frequent injuries, depressive and anxiety states, chronic gastritis, elevated blood pressure and many other health problems. Data on the use of alcohol, tobacco, coffeine, psychoactive medicines and illicit drugs should become an integral part of the patients' medical records. The use of simple, yet reliable tests would enable doctors and nurses to differentiate problem drinkers from alcoholics. By means of brief and structured procedures the consumption of alcohol in a given population could be significantly reduced. Physicians who want to do more for their patients can learn how to motivate them to improve their lifestyles by remaining sober, giving up smoking and adopting new dietary patterns.

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