In conclusion, plasma level monitoring of the enantiomers of MTD is recommended when MTD treatment has to be adapted in patients. The knowledge of the enzymatic mechanisms which are implicated in the stereoselective biotransformation of MTD helps to select appropriate comedications in MTD-treated patients, if needed.

ULTRA-RAPID OPIATE DETOXIFICATION: A CLINICAL INVESTIGATION

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Although largely discussed in public media, there are few scientific reports about the ultra rapid detoxification procedure during which the opiate addict is given a benzodiazepine-induced general anaesthetic while an opiate antagonist is administered. These scarce reports are generally enthusiastic about this method whereas many experienced clinicians are rather reluctant to develop upon it. Clearly more clinical studies are needed.

We report an open study with twenty patients treated using a procedure of direct transition to naltrexone (50 mg) twenty to thirty minutes after the oral administration of midazolam (90 to 120 mg), clonidine (0.300 mg), ondansetron (8 to 16 mg) and an anti-diarrhoea medication. Seventeen patients were on methadone maintenance (among them 4 regularly using heroin) and three patients were heroin dependent. The indications were detoxifications before admission in a therapeutic community (n = 4), a long lasting stay abroad (n = 4) or transition to a naltrexone out-patient treatment (n = 12). The procedure appears to be safe: no serious problems occurred. Patients were able to sleep most if not all of the first 5–8 hours, although they could not be considered anaesthetized. Clonidine and other comedications were prescribed for the rest of the first day and the next few days, but most of the patients were able to leave the hospital 36 hours after their admission. The procedure however was not well tolerated: almost all the patients had diarrhoea and/or vomitting. A six month follow-up has shown a high rate of relapse (80%) as usual after any detoxification and a rather high variability among the patients self-evaluated satisfaction.

After these first twenty patients, we modified the method and introduced a transition to a mixed agonist-antagonist (buprenorphine) one a week before transition to naltrexone, resulting in a better clinical tolerance to the detoxification, particularly for vomitting and diarrhoea. The future of the method probably relies on this two step transition: full agonist/mixed agonist-antagonist/full antagonist. This method could than find a place among the different detoxification methods although the indications will probably remain limited.

BUPRENORPHINE IN THE TREATMENT OF OPIATE ADDICTION

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Buprenorphine is a semi-synthetic opioid with agonist/antagonist properties. Since 1980, its pharmacological properties have led some to suggest that it could be used in the treatment of heroin addicts (Mello and Mendelson, Science. 1980; 207: 657–659).

In 1985, we published the first study of maintenance treatment of opiate-dependent subjects with buprenorphine (Drug Alcohol Depend 1985; 16: 257–262). Of 34 patients followed over a period of 2–17 months, 5 (15%) finished treatment after a progressive decrease in the dose of buprenorphine (starting around 2 mg/day). Their treatment lasted 2 months in one case and 7–8 months in the 4 others. Urine samples collected 3–12 months later were free of opiates; 26 (76%) patients were still in treatment; 3 (9%) patients abandoned treatment after 4–8 months.

More than 90% of the patients who undertook the treatment with buprenorphine for more than 2 weeks followed it. However, almost 50% of the addicts to which treatment was proposed abandoned it after less than 2 weeks. This high percentage of dropouts at the beginning might be due to the fact that the initial dosage of buprenorphine was too low for those patients.

In fact, recent studies have shown that 2 mg of buprenorphine were inferior to 35 mg of methadone in reducing illicit opioid use (Kosten and al., J. Nerv. Ment. Dis. 1993; 181: 358–364) and that 8 mg/day of buprenorphine were as effective as 60 mg/day of methadone (Johnson et al., JAMA 1992; 267: 2750–2755). As 50 mg of methadone is now widely accepted as the lowest effective dose, it appears that buprenorphine effective dose should be higher than 2 mg/day.

Under this condition, buprenorphine may be an interesting alternative to methadone treatment, especially since regulations make the availability of methadone treatment inferior to the demand in many countries. One advantage of buprenorphine treatment may be that the possibility of lethal overdose is remote owning to the opiate antagonist properties of buprenorphine (Cowan and Lewis, Buprenorphine, Wiley-Liss, 1995: 247).

MORTALITY IN THE METHADONE-MAINTENANCE-PROGRAM/NORDRHEIN WESTFALIA, GERMANY

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In a retrospective analysis all cases of death among patients of the Methadone-Maintenance-Program in Nordrhein Westfalia are reviewed and evaluated. Patients who died after exclusion from substitution are analysed with special attentiveness.

In a 6 years observation period, 27 patients out of the total number of 244 died by different reasons. The cumulated death risk related to the real number of a defined cohort was about 15% after 6 years. Half of them died by drug related reasons.

It is shown, that patients excluded from substitution by different reasons show a highly increased risk of drug related mortality in the near future.

So the cumulated probability after a 6 years observation period to stay alive (it means not to die by drug related causes) for patients remaining in substitution (n = 184) is about 98%, whereas in the excluded population (n = 60) the correspondent value is only about 77%.

This finding indicates a protective effect of this methadone-program on the drug related mortality. Aspects of psychiatric comorbidity and possible consequences for treatment settings are discussed.

S18. Ethnic diversity and mental health in Europe

Chairmen: J van Os, D Brugha

PROVIDING MENTAL HEALTH CARE FOR IMMIGRANTS

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International migration is increasingly affecting industrialised coun-

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tries. Along with the natural growth of foreign and foreign-born populations, new influxes due to either labour recruitment, family reunification or request for political asylum are playing an important role. It is clear that as the demography of most countries in Europe continue to shift, therapists will increasingly work with clients who have backgrounds and cultural expectations highly dissimilar to their own.

The importance of preserving and fostering the health of immigrant communities has only been recently acknowledged. As of today, many receiving countries have limited information on the health status of their immigrant populations; evidence is increasing, however, that individuals from ethnic minority groups have worse mental health status.

On the political level, it is clear that the health and health care delivery to non-native ethnic groups need to be considered in the frame of both national immigration policies and health system structure, because both factors could greatly influence entitlement and access to health services. An important issue is if immigrant communities are allowed to participate in the political discussions about the mental health care system and whether or not they can organize their own ethnopsychiatric system.

On the institutional level, the health status of immigrants can be attributed to various barriers to access to mental health care (financial, linguistic, cultural); lack of training of health professionals; racism and lack of attention to the needs of ethnic communities within the health system. The benefits and risks of engaging allochtonous care providers will be discussed.

At the individual level, the eurocentric basis of educational programs may equip students for work with middle class white people and highly acculturated immigrants, but most are not trained to conduct accurate clinical assessments of more culturally diverse clients. The benefits of systematic introduction of anthropological knowledge in euro-mental health education, and modification of eurocentric forms of treatment will be discussed, and alternatives suggested.

PSYCHOPATHOLOGY AND MIGRATION: AN EPIDEMIOLOGICAL STUDY

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Objectives: There have been many reports of increased incidence of psychiatric disorders in ethnic minority groups from the Caribbean and North Africa living in Northern European countries. Little is known about psychiatric morbidity associated with migration *within* Europe. *Method:* The administrative incidence for all psychiatric disorders were determined for Italian individuals living in a defined area in Southern Switzerland. In this area, Italians constitute around one-fifth of the total population. *Results:* Preliminary results indicate that, over the period 1991–1992, the raw administrative incidence rates were nearly twice as high for the Italian group, as compared to the Swiss group (including a small group of immigrants from other countries): 136.3 per 100,000 person-years in the Italian group, and 79.6 per 100,000 person-years in the Swiss group (rate ratio: 1.7, 95% confidence interval: 1.4–2.1). *Conclusions:* The findings suggest a substantially increased risk for psychiatric morbidity in the Italian population living in Southern Switzerland. Further investigations should shed light on which of several possible explanations for this finding is most likely: i) differences in socio-demographic composition of the source populations, ii) a selective increase in a particular diagnostic group, such as psychosis or alcohol-related pathology, iii) differences in the pathway to care.

EVIDENCE FOR PSYCHOSIS OF GOOD PROGNOSIS IN PEOPLE OF CARIBBEAN ORIGIN LIVING IN THE UK

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Cross cultural studies have shown that the prognosis of psychotic disorders is better in non-industrialised countries. Some researchers have questioned whether the reported increased incidence of psychosis in people of Caribbean origin living in the UK may be due to an excess of such good prognosis illness.

The objective of this study was to compare the course and outcome of psychotic illness in a group of Caribbean people resident in the United Kingdom and a group of white British patients.

A cohort of 113 patients with psychosis, admitted consecutively to two south London Hospitals, was followed up over an average of four years.

Multiple sources of information were used including relatives, general practitioners, family members, spouses, hospital and hostel staff and case notes.

The black Caribbean group spent more time in a recovered state during the follow-up period (adjusted odds ratio 5.0 95% confidence interval 1.7–14.5) and were less likely to have a continuous illness (0.3; 0.1–0.9).

There were no differences in hospital use. These findings persisted after adjustment for possible confounding variables such as age of onset, childhood social class, DSM diagnosis, sex and length of illness.

We conclude that black Caribbean patients have a better outcome after psychotic illness than do white patients and the high incidence of psychosis in this group may be due, at least in part, to an excess of good prognosis illness.

The presence of environmental precipitants, "life events", predicts better prognosis. The better prognosis shown here may be due to a higher prevalence of illness with social precipitants.

REFUGEE MENTAL HEALTH IN EUROPE: AN OVERVIEW OF EPIDEMIOLOGY AND TREATMENT INTERVENTIONS

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In this paper, we will discuss recent trends in numbers of refugees in Europe. The advantages and disadvantages of different models for psychosocial interventions in refugees with mental health problems will be considered. Suggestions will be made about future research on psychosocial interventions for adult refugees, concentrating on further development of effective and efficient treatment for those who have developed serious and physical symptoms as a result of extreme stressors.

HIGH INCIDENCE OF SCHIZOPHRENIA IN SURINAMESE AND ANTILLEAN IMMIGRANTS TO HOLLAND

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Introduction: Reports of a high incidence of schizophrenia in Afro-Caribbeans in the UK are a matter of much debate. In recent decades many immigrants from Surinam and The Netherlands Antilles have settled in Holland. More than one third of the Surinamese-born population now lives in Holland. We compared the risk of a first discharge for schizophrenia (ICD-9) for young (15–39 yrs) immigrants from Surinam and the Antilles to that for their native-born peers in the period 1983–92.