2.5 Drug dependence treatment

Key recommendations

- The primary objective of treatment systems for drug dependence should be to enable individuals to enhance autonomy and live fulfilling lifestyles
- Although abstinence may be a worthy goal, it may not be achievable or appropriate for some individuals, who should be given the right to remain under substitution therapy should they wish to do so, and as long as they deem it to be necessary
- Policy makers should make a long-term investment in treatment, in order to adequately respond to drug dependence and reduce its associated health and social costs
- Investments in drug dependence treatment should demonstrate a systemic approach rather than a w of isolated interventions: it should identify those most in need of treatment; offer a balanced menu of evidence-based services; and develop smooth mechanisms for individuals to move between different elements as their circumstances change
- Approaches that breach human rights standards (such as the compulsory detention of people who use drugs) should not be implemented. Not only are these unethical, they are also highly unlikely to achieve the desired aims and are not cost-effective
- More research should be conducted on the treatment of stimulant dependence
- It is necessary to constantly review and evaluate national treatment systems to make sure that they are operating effectively and in accordance to global evidence. Services can be made more effective and responsive if they include the meaningful involvement of clients in their design and delivery.

Introduction

There is an increasing trend to view drug dependence in health terms rather than as a criminal and/or moral problem. Recent estimates suggest that in 2013, approximately 246 million adults used controlled drugs for non-medical purposes (range 162 to 329 million).[124] Of this total, just one in ten (approximately 27 million adults), were estimated to be dependent on drugs.[125]

Evidence-based drug dependence treatment has proved effective in managing drug dependence, reducing drug-related harms and minimising social and crime costs. Available data demonstrate that opioid substitution therapy (OST) improves retention in treatment and reduces illicit opioid use,[126] thereby reducing the incidence of injecting, and consequently exposure to blood-borne viruses such as HIV and hepatitis C.[127] However, only one in six people dependent on drugs has access to evidence-based drug treatment.[128] In view of this situation, access to OST should be scaled up to address the unmet need that currently exists worldwide.

The range of drugs available is itself increasing, and a model effective for one (for example opioids) may not be effective for another (for example crack, methamphetamines, etc.). There is therefore an urgent need to give more prominence and attention to substitution treatment options for other substances, in particular stimulants. Indeed, pilot studies on the treatment of methamphetamine dependence using dexamphetamine, as well as on the use of cannabis to reduce crack dependence, have shown promising results.

There is a clear economic case for expanding investments in drug dependence treatment, as investments can lead to large-scale savings in health, social and crime costs.[129] A 2010 study by the UK Home Office estimated that for every £1 (US$1.40) spent on drug dependence treatment, society benefits to the tune of £2.50 (US$3.60).[130] Research in the USA has estimated that the benefit return for methadone maintenance treatment is around four times

Credit: International HIV/AIDS Alliance

A nurse measures out methadone at Ar Rahman mosque in Kuala Lumpur, Malaysia

the treatment cost.[131] Indeed, according to the National Institute on Drug Abuse, 'The average cost for 1 full year of methadone maintenance treatment is approximately $4,700, whereas 1 full year of imprisonment costs approximately $18,400 per person',[132] concluding that 'Research has demonstrated that methadone maintenance treatment is beneficial to society, cost effective and pays for itself in basic economic terms'.[133]

The impact of drug use on individuals depends on the complex interaction between the pharmacological properties of the substance used, the attributes and attitudes of the person who uses drugs, and the environment in which consumption takes place. Treatment interventions need to consider each of these factors and how they interact. In all societies, the prevalence of drug dependence has been largely concentrated among marginalised groups, where rates of emotional trauma, poverty and social exclusion are highest.[134] Given the many factors that drive drug dependence, no single approach to treatment is likely to produce positive outcomes across society. Therefore, policy makers should work towards a treatment system that encompasses a range of models that are closely integrated and mutually reinforcing – and that takes into account the choice and preferences of the person accessing treatment. The impact of the legal and physical environment means that effective treatment interventions should offer both medications and psychosocial services, while taking into account the impact of the social and cultural setting in which they do so. Such interventions, as part of an effective treatment system, can enable an individual to live a healthy and socially constructive lifestyle.

Legislative/policy issues involved

International obligations

The obligation on UN member states to provide drug treatment to their citizens is embedded in the international drug control conventions. Under Article 38 of the 1961 Single Convention on Narcotic Drugs, and article 20 of the 1971 Convention on Psychotropic Substances, signatory states are required to take practical measures for 'the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved'.[135]

Moreover, the right to treatment is included in the more general obligations relating to the right to the enjoyment of the highest attainable standard of physical and mental health ('the right to health'). The right to health was first articulated in the Constitution of the World Health Organisation in 1946, and mentioned in the Universal Declaration of Human Rights two years later.[136] These are foundational documents in the UN system, and the inclusion within them of the right to health demonstrates the importance with which the concept is endowed in international law. The preambles to the UN drug control conventions reinforce these principles; the first words of the 1961 Convention and the 1971 Convention express member states' concern 'with the health and welfare of mankind'.[137] And, as the former High Commissioner for Human Rights stated: 'Individuals who use drugs do not forfeit their human rights'.[138]

Ensuring access to essential medicines for OST

Both methadone and buprenorphine are included in the WHO Model List of Essential Medicines.[139] According to human rights treaties within which the right to health is protected, such as the International Covenant

Box 1 Heroin-assisted treatment (HAT) – the UK example

An estimated 5% of opioid users in substitution treatment do not respond well to treatment with methadone. They are often among the most marginalised of people who use drugs and may experience a range of severe health and psychosocial problems. This may result in high costs in terms of welfare and engagement with the criminal justice system.

In the UK, there is a history of prescribing injectable heroin to people dependent on opioids. However, in the 1960s and 1970s, this practice became politically controversial, mainly because people collected take-away doses from pharmacies, with very little supervision. It is probable that this prescribing fed an illicit market. By the mid- to late-1970s, the prescribing of heroin ceased almost entirely. Nonetheless, there continued to be an unmet therapeutic need among a highly vulnerable section of people dependent on drugs, who did not progress with methadone and tended to purchase and use illicit supplies of heroin in addition to, or instead of, their methadone doses.

In recent years, a new and politically more acceptable regime of HAT was developed in Europe, especially in Switzerland.[141] The UK began scientific trials of this method, in which clients received doses of injectable heroin in special clinical facilities, under controlled conditions, with close supervision and support from medical staff in a clean and secure setting.[142]

Many of these clients found it to be a life-changing experience, and saw significant improvement in their health and social well-being, alongside large reductions in illicit drug use and associated criminal activity. The trials involved the clients in peer support and research assistant capacities. The researchers found that HAT enabled a hard-to-reach and hard-to-treat population to access healthcare and support services, as well as meeting political and public order objectives and the requirements of clinical safety.[143]

A recent systematic review and meta-analysis of randomised controlled trials with HAT has been carried out by some of the researchers involved in these trials. Those reviewed were carried out in Canada, Germany, the Netherlands, Spain, Switzerland and the UK. The research concluded that 'heroin-prescribing, as a part of highly regulated regimen, is a feasible and effective treatment for a particularly difficult-to-treat group of heroin-dependent patients'.[144]

on Economic, Social and Cultural Rights, the medicines that signatory states are obliged to make available must be 'scientifically and medically appropriate'.[140]

In countries such as the Netherlands, the UK and Switzerland, governments have developed successful treatment programmes providing a large range of options, including substitution with methadone and buprenorphine, but also with morphine and heroin (see Box 1). It is essential that drug laws and policies be reviewed to ensure adequate access to these substances for OST.

In some countries, however, people who use drugs have lost their fundamental right to health. In Russia, Turkmenistan and Uzbekistan, for instance, the use of methadone is prohibited by law. This is despite the fact that the United Nations Office on Drugs and Crime (UNODC) estimates that 2.29% of the adult population of Russia are injecting drugs. A third of the global total of people who inject drugs living with HIV reside in Russia.[145] The proportion of Russian AIDS cases linked to injecting drug use is estimated at 65%, while around 35% of people who inject drugs are living with HIV.[146] The country is subject to epidemic levels of both injecting drug use and HIV, yet the availability of the treatment with the most extensive evidence base, OST, is blocked by the Russian government. In other countries where methadone is available, buprenorphine remains illegal, as is the case in Mauritius – leaving limited treatment options for people dependent on opioids.

Ending compulsory detention

In many countries, treatment systems for drug dependence are non-existent or under-developed, or pursue models inconsistent with human rights standards and global evidence of effectiveness. Research, experience and international human rights instruments indicate that certain treatment practices should not be implemented. Some governments, for example, have introduced treatment regimes that rely on coercion, ill-treatment, denial of medical care, or forced labour.[147]

In China and South East Asia, including in Vietnam, Cambodia, Malaysia, Thailand and Lao People's Democratic Republic, the use of compulsory centres

for drug users (CCDUs) as a mode of rehabilitation is a widely accepted and common practice.[148] The use of compulsory detention is also found in Latin America and Central Asia.

CCDUs are generally run by the police or military rather than health authorities, and people caught using drugs are forced to stay in such facilities, frequently without due legal process or judicial oversight, sometimes for several years. They are denied scientific, evidence-based drug treatment, and can be subjected to forced labour, which is either unpaid or paid well below minimum wage levels, as well as a range of punishment such as physical, psychological and sexual abuse, and solitary confinement. General medical healthcare is often non-existent, and diseases such as HIV and tuberculosis are widespread among detainees.

CCDUs are also very costly and ineffective. Relapse rates are very high (in Vietnam, for example, from 80% to 97%)[149] and detainees face challenges with social reintegration largely due to the stigmatisation associated with being detained for using drugs. Although certain governments in the region have recently introduced new drug laws that have modified the status of people who use drugs from 'criminals' to 'patients', such as China's 2008 Anti-Drug Law and Thailand's 2002 Narcotic Addict Rehabilitation Act, the humanitarian rhetoric of these legal texts is unrepresentative of the reality of life in the compulsory centres, which impose cruel and dangerous punishments under the guise of treatment.[150] These conditions violate scientific and medical standards, as well as international human rights law.

In 2012, a joint statement supported by 12 UN agencies called for the closure of compulsory detention centres on the grounds that they violate human rights and threaten the health of detainees.[151] The UNODC and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have since run a series of consultations on compulsory centres. The third consultation took place in September 2015, and was attended by drug control, health and finance officials from Cambodia, China, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Thailand and Vietnam. These countries agreed to sign up to a 'roadmap' toward evidence-based support services for people who use drugs.[152]

Nonetheless, there is a clear need to accelerate national-level transitions to voluntary, community-based drug dependence treatment and support services, which require corresponding reforms to drug laws and policies in order to remove incarceration and other punitive responses for people who use drugs. Although the process may be a slow one, the UN and civil society stakeholders have worked hard to develop guidance and recommendations on the way forward, and elements of community-based treatment have already been established in Cambodia, China, Indonesia, Malaysia, Thailand and Vietnam.[153]

A guard keeps an eye on the detainees of a Vietnamese compulsory detention centre before they head to their working morning session

Credit: 2011 Private, Human Rights Watch

Box 2 A community-based treatment model in Indonesia

Rumah Singga PEKA (PEKA) is a local civil society organisation based in Bogor, Indonesia, offering treatment options for people who inject drugs. The overall objective of PEKA is to improve the quality of life of people who use drugs. As such, it relies heavily on client-centred approaches to deliver tailored health services that adequately meet the needs of people who use drugs. Access to treatment is voluntary and people can withdraw from the programme at any time. Treatment includes both in-patient and community-based options. Clients can choose between an intensive two-months programme (involving detoxification, peer counselling, psychosocial support, life-skills training, relapse prevention and social and vocational activities) or a non-intensive four-months programme (involving counselling, life-skills training, relapse prevention and social and vocational activities).

Clients have the option of entering OST (with both methadone and suboxone), primary and reproductive healthcare, HIV counselling and testing, ART, testing and treatment for hepatitis C, tuberculosis and STIs. To do so, PEKA has established a comprehensive network of hospitals, community health centres, health laboratories and private psychiatrists to facilitate effective health referrals for clients. Sterile injecting equipment is available for all clients. Finally, PEKA mobilises people who use drugs to participate in advocacy interventions and campaigns.

In 2013, PEKA reached a total of 786 people using drugs. Among those, 95 received inpatient treatment, and 691 were reached via community outreach, 670 were referred to HIV counselling and testing, and 13 to OST. In 2014, an additional 250 inmates received training and education sessions in four prisons.[154]

Implementation issues involved

The complexity of drug dependence is such that the response, setting and intensity of treatment need to be tailored to each person. It is therefore essential that a comprehensive menu of services is made available to suit the differing characteristics, needs, preferences and circumstances of each person wishing to access treatment. Moreover, treatment programmes should be thoroughly integrated with prevention and harm reduction services, and have effective linkage(s) with criminal justice, public health and social welfare services.

Entering a treatment programme

There are a number of potential routes through which a person can approach treatment services without falling into the trap of coercive treatment models or compulsory detention:

- Self-referral – Sufficient information should be available for people to be aware of the range of treatment services available
- Identification through general health and social service structures – Existing healthcare and social services will often be in an excellent position to recognise symptoms of drug dependence and encourage the person to ask for specialist help. For example, general practitioners are often trusted by their patients and can play a key role, provided they have sufficient training on drugs and drug dependence
- Identification through specialist drug advice centres or street outreach services – These services can offer food, temporary housing, low-threshold harm reduction services, and mechanisms to refer people to drug treatment programmes on a voluntary basis
- Identification through the criminal justice system – Through the illicit nature of their drug use, and the need to fund it, people dependent on drugs may come into contact with the criminal justice system. A range of referral schemes can be established to offer people dependent on drugs who have committed low-level offences opportunities to attend a treatment programme (see Chapter 3.4 for more information).

Treatment methods

Multiple methods of evidence-based treatment should be available, ranging from substitution therapy to psychosocial support and abstinence-oriented approaches, so that those seeking treatment may select the most appropriate form for themselves. When the treatment method chosen is substitution therapy, it is essential that medical staff providing the treatment be adequately trained, and that the dosage of the substitution drug is adequate for the needs of the client.

As the range of substances being used is expanding – and the demand for treatment for stimulant dependence is increasing – governments and

scientists are now playing catch-up to develop effective systems of treatment for methamphetamines (see Box 3), crack (see Box 4), and new psychoactive substances (NPS). Some countries have established extensive treatment systems over many decades, while others are just starting to develop experience and understanding of this policy area. However, all countries have some way to go to achieve a sufficiently integrated range of treatment services for drug dependence that makes effective use of available resources to maximise health and social gains.

Treatment success and recovery should not be understood only as abstinence from drug use. Recovery encompasses any positive step or change that leads to the improvement of the person's health, well-being and overall quality of life. This is particularly true for people under substitution therapy,[155] but also for people who have learned to control their drug use in order to minimise the health and social harms associated with it (for example, see Box 4).[156] Recovery is therefore incremental, and it is up to each individual to decide what their goal towards recovery will be within their treatment programme.

Treatment setting

As well as offering a variety of evidence-based interventions, an effective treatment system should also deliver interventions in a range of environments. Treatment can be community-based (such as regular attendance at a clinic where clients receive prescribed medications, psychosocial support and counselling, etc.), residential, or delivered in other health services such as drop-in centres or harm reduction facilities. It is difficult to be prescriptive about which should receive the greatest emphasis, as this will vary according to the particular needs of the person, available resources, and the availability of trained medical professionals – for maximum coverage, a combination of all of these settings constitutes the best option. Community settings tend to be less costly in resource-constrained environment, and may be more appropriate where there is strong social, family and community support for the person dependent on drugs. However, it can sometimes be better for the client to be treated away from their home area when these supports are absent. Such decisions should be made on an individual basis, by the client and therapist working in partnership, as part of a care plan. The chain of care should be thoroughly integrated – as clients may wish to move across all three of these settings during their treatment programme, according to their needs.

Box 3 Treatment for amphetamine-type stimulants

Methamphetamine and other ATS are the second most widely used drugs globally, after cannabis.[157] These stimulants can be associated with considerable levels of health harms, including psychological problems and medical complications, many of which can be severe in the case of heavily dependent use.[158] Current treatment for ATS use is predominantly behavioural, with cognitive behavioural therapy amongst the most frequently given treatments.

Substitution therapies are not widely available to people who use ATS, as the evidence base remains nascent.[159] Many prescribed psychostimulant substances have been proposed and utilised, including modafinil and dexamphetamine. In addition, dopamine agonists, anticonvulsants, antidepressants and antipsychotics have been used in trials of treatments for amphetamine. In Melbourne, Australia, dexamphetamine was prescribed in a supervised setting to a group of long-term ATS injectors. They reported that dexamphetamine reduced their drug cravings, and alleviated the symptoms of withdrawal. Approximately half became abstinent, according to self-report (although no urine analysis was carried out to confirm the abstinent status).[160]

However, it is highly unlikely that a single substitute will be found suitable for treatment of the diverse range of ATS on the market. With ATS now a global commodity with prolific individual and social harms, it is important for researchers, pharmaceutical manufacturers and governments to cooperate in the urgent identification of new substitution treatments for ATS and other substances, such as cocaine.

Effective aftercare support

Many people dependent on drugs are economically vulnerable and socially excluded, mainly because of the high stigma and discrimination resulting from the criminalisation of drug use (see Chapter 3.1). A crucial objective of treatment is to improve people's engagement in society. This means raising levels of education, facilitating access to employment and housing, and offering other social support. A key element of this process is the strengthening of so-

Box 4 Evidence for crack dependence treatment: The case for medical cannabis

In Brazil, the use of crack is associated with a number of health and social harms, including marginalisation, violence, increased vulnerability to HIV, or involvement in petty crime and sex work. The lack of adequate harm reduction and treatment measures offered by the government has led people using crack to develop their own strategies for minimising these harms, in particular cravings and psychosis. Such measures have included combining crack use with cannabis.[161]

A 2015 qualitative study using interviews among 27 Brazilian people combining cannabis and crack consumption showed that this technique reduced craving for crack, improved people's sleep and appetite, and 'protected' them from the violence often associated with crack culture in the country – therefore improving their overall quality of life.[162] A 1999 study among 25 young men dependent on crack in Brazil showed similar results – 68% of those involved in the study stopped using crack and reported that cannabis use had reduced craving symptoms.[163]

The local government in Bogota, Colombia introduced a similar initiative in 2013 in an effort to assess whether cannabis use could alleviate the harms associated with crack use.[229] Uruguay is also considering the use of medicinal cannabis for people dependent on cocaine and pasta base.[165]

cial and community ties. The engagement of people who use drugs – current and former – in treatment settings can do much both to enhance feelings of self-empowerment and to improve the quality and responsiveness of services.

The goal of drug treatment should be, if possible, to assist a person dependent on drugs to achieve a high level of health and well-being. In this context, it is necessary to recognise that some people may find it impossible or undesirable to attain abstinence. However, this needs not preclude the main objective of treatment, that of helping clients to live happily and productively. Indeed, many people who are dependent on opioids are perfectly able to successfully achieve this while remaining on OST.

Key resources

- Council of the European Union (September 2015), *Council conclusions on the implementation of the EU Action Plan on Drugs 2013-2016 regarding minimum quality standards in drug demand reduction in the European Union*, http://www.emcdda.europa.eu/news/2015/eu-minimum-quality-standards
- Tanguay, P., Stoicescu, C. & Cook, C. (October 2015), *Community-based drug treatment models for people who use drugs*, http://www.ihra.net/files/2015/10/19/Community_based_drug_treatment_models_for_people_who_use_drugs.pdf
- United Nations Office on Drugs and Crime (2012), *TREATNET Quality standards for drug dependence treatment and care services*, https://www.unodc.org/docs/treatment/treatnet_quality_standards.pdf
- United Nations Office on Drugs and Crime & World Health Organisation (2008), *Principles of drug dependence treatment*, http://www.who.int/substance_abuse/publications/principles_drug_dependence_treatment.pdf
- World Health Organisation (2001), *Management of substance dependence review series – Systematic review of treatment for amphetamine-related disorders*, http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.5.pdf
- World Health Organisation (2009), *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*, http://www.who.int/substance_abuse/publications/Opioid_dependence_guidelines.pdf
- World Health Organisation (2011), *Therapeutic interventions for users of Amphetamine Type Stimulants (ATS)*, WHO Briefs on ATS number 4, http://www.idpc.net/sites/default/files/library/WHO-technical-brief-ATS-4.pdf
- World Health Organisation, United Nations Office on Drugs and Crime & Joint United Nations Programme for HIV/AIDS (2004), *WHO/UNODC/UNAIDS Position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf