
VISITING EXPERT'S PAPER

THE CURRENT SITUATION, CHALLENGES AND FUTURE DIRECTION OF DRUG USE AND DEPENDENCY, OVERVIEW OF INTERNATIONAL DRUG CONVENTIONS AND UNODC-WHO PRINCIPLES OF DRUG DEPENDENCE TREATMENT

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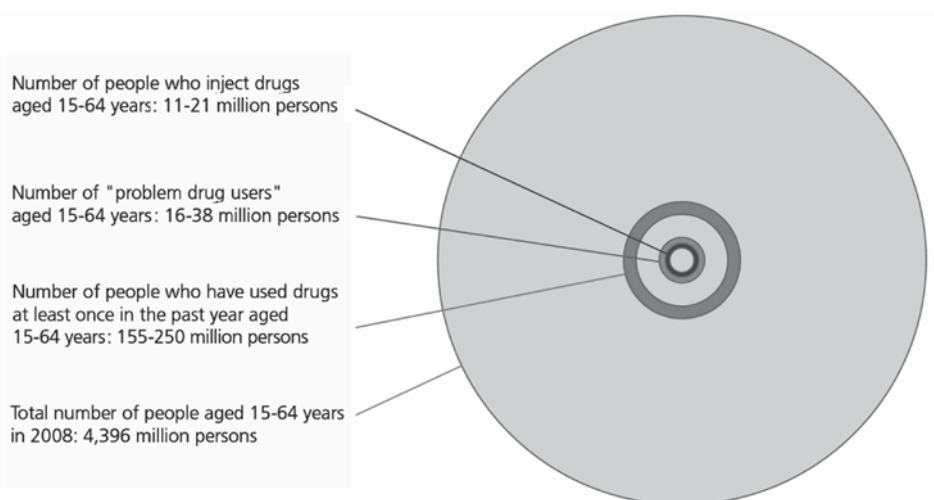


I. THE CURRENT SITUATION, CHALLENGES AND FUTURE DIRECTION OF DRUG USE AND DEPENDENCY

There have been a number of encouraging developments in global cocaine and heroin markets in recent years, including:

- The global area under opium poppy cultivation in 2010 amounted to approximately 195,700 hectares, which was some 12% lower than the area under opium cultivation ten years earlier in 2000. However, a 20% increase in opium poppy cultivation has been reported in Myanmar since 2009 and there is indication that cultivation may be on the increase again in Afghanistan.
- A decline in global opium production, from 8,890 metric tons in 2007 to 7,754 metric tons in 2009 (-13%);
- A decline in the potential production of heroin from 757 metric tons in 2007 to 657 metric tons in 2009;
- A decline in the global area under coca cultivation to 158,800 hectares in 2009 (5%), by 28% since 2000; and
- A decline in global cocaine production, from 1,024 metric tons in 2007 to 865 metric tons in 2008 (-16%).

Globally, UNODC estimates that between 155 and 250 million people (3.5 to 5.7% of the population aged 15-64) used illicit substances at least once in 2008. Globally, cannabis users comprise the largest number of illicit drug users (129 - 190 million people). Amphetamine-group substances rank as the second most commonly used drugs, followed by cocaine and opiates. Many countries are reporting a shift away from use of opiates and cocaine towards use of Amphetamine Type Stimulants (ATS).



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The number of people aged 15-64 years with problematic drug use was estimated to range from 16 to 38 million. This represents 10% to 15% of all people who used drugs that year. The estimated number of people who inject drugs ranges from 11 to 21 million people aged 15-64. In terms of access to treatment, it was estimated that in 2008, globally, between 12% and 30% of problem drug users had received treatment in the past year, which means that between 11 and 33.5 million problem drug users did not receive treatment in that year.

In terms of prevalence of illicit drug use, the estimated annual prevalence ranges from 3.5% to 5.7%, while the estimated prevalence of illicit drug use in the past month ranges from 2.0% to 3.3% and problematic drug use from 0.4% to 0.9%, respectively. In comparison, an estimated 25% of the population aged 15 and above smoked tobacco in the past month. Disease burden studies by the World Health Organization indicate that tobacco and tobacco related causes of death accounted for 5 million deaths, while alcohol accounted for 1.8 million deaths, in comparison with 200,000 deaths caused by use of illicit drugs.

The estimated annual prevalence of illicit drug use among 15-64 year olds who used cannabis in 2008/2009 ranged from 2.9% to 4.3%. Between 0.3% to 1.2% had used amphetamines in that year, while annual prevalence of ecstasy-group substances ranged from 0.2% to 0.6%, opiates from 0.3% to 0.5% and cocaine from 0.3% to 0.4%, respectively.

It must be recognized that absence of or poor quality of data in many countries in Asia still limits the understanding of the drug use problem in many countries and that the broad range of the estimates reflects the uncertainties in the available data on drug use. Data limitations are even more acute when determining the size of the demand for amphetamine-type stimulants (ATS). In many countries in the world – particularly developing countries – demand related data on prevalence, patterns and extent of drug use are not collected or not regularly collected, thus accounting for a substantial amount of uncertainty reflected in prevalence estimates with wide ranges. Bearing in mind these limitations, past year amphetamine-group and ecstasy-group users are estimated to be in the range of 14 to 53 million and 10 to 26 million, respectively. Thus the global number of ATS users is likely continue to exceed the number of opiate and cocaine users combined.

The cultivation of opium is generally reported to be contained and there are indications that the downward trend in global opium production over the 2007-2009 period will continue in 2010. Afghanistan continues to be the source of most of the world's illicit opiates. However, significant quantities of opium are also produced in Myanmar and Latin America, mostly in Mexico and Colombia. The cultivation of opium in Afghanistan appears to have been stable since 2009. The world's largest heroin market is West Europe, and about half of this market is contained in just three countries: the United Kingdom, Italy and France. The Russian Federation accounts for 21% of the global heroin market while China accounts for 13%.

According to the *Opium Survey in South East Asia* conducted by UNODC in 2010, the major portion of opium poppy cultivation in South East Asia takes place in Lao PDR, Myanmar and Thailand. Between 1988 and 2006, the cultivation of opium in these three countries decreased. However, since opium poppy cultivation has increased in Myanmar and a mixed pattern of increases and decreases have been observed in Lao PDR and Thailand since 2008, overall, opium poppy cultivation in the region has almost doubled since 2006. In a survey of farmers, reasons given for growing of poppy included buying food (77%), own consumption (9%), lack of options to grow other crops (5%), and to get more cash (4%) among other reasons (5%).

While most countries in East and Southeast-Asia have reported some decrease in the use of opiates, between 2.8 and 5 million people aged 15 to 64 were estimated to have used opiates in the past year in the sub-region. Opiates, and especially heroin, are still reported as the most prevalent drug in China, Indonesia, Malaysia and Myanmar. The highest prevalence of opiate use of 1.3% and 1.2% respectively in this sub region are estimated to be found in Malaysia (among the population aged 15-64, 2002). The use of heroin has been reported to be a re-emerging problem in East and Southeast Asia. Its use has been reported to be on an increase in Lao PDR, Thailand and Vietnam.

A review by the Reference Group to the United Nations on HIV and Injecting Drug Use in 2008 indicated that of the estimated 15.8 million (11.0–21.2 million) injecting drug users (IDUs) globally, 3.9 million (range

3.5 to 5.6 million), or 25%, live in South, East and Southeast Asia.¹ A high prevalence of HIV among people who inject drugs has been reported by several countries in East and Southeast Asia, including Indonesia (57.1% of women who inject drugs and 52.1% of men who inject drugs), Thailand (38.7%), Myanmar (36.3%), Cambodia (24.4%), Malaysia (22.1%), Vietnam (18.4%) and China (9.3%).²

UNODC estimates that between 13.7 and 52.9 million people used amphetamine-group substances at least once in the preceding year, with a corresponding annual prevalence range of 0.3% to 1.2% of the population aged 15 to 64. Amphetamine-type stimulants (ATS) refer to a group of synthetic substances comprised of amphetamine-group (primarily amphetamine, methamphetamine and methcathinone) and ecstasy-group substances (MDMA and its analogues). ATS can be made anywhere the precursors can be found, so manufacturing tends to happen close to the where there is a market and demand for ATS.

ATS drugs, particularly methamphetamine (in pill or crystalline form), are widely used in East and Southeast Asia. It is estimated that between 3.4 million and 20.7 million persons in the region had used amphetamines in the past year. In many countries in the region, ATS have become the primary drug problem, displacing traditionally used drugs such as heroin, opium or cannabis. ATS now rank in the top three drugs of use in all countries in East and Southeast Asia. Increasing trends in the use of methamphetamine have been reported from most countries in the region (Cambodia, China, Indonesia, Malaysia, Myanmar, Philippines, Republic of Korea, Singapore, Thailand and Vietnam) whereas use has been reported as declining in Japan and the Philippines. The use of crystalline methamphetamine ("Ice") is also on the increase in China, Thailand and Vietnam.

Several countries also report an increase in the use of ecstasy, with Brunei Darussalam, China and Vietnam indicating increasing use. Despite the rising numbers of ATS users in several countries and an increase in demand for ATS related treatment, few specialist treatment services are available. Often, drug treatment services for users of ATS and other synthetic drugs are under-resourced and unable to keep pace with the increasing number of people with problematic ATS use.

Another challenge reported by countries in East Asia and Southeast Asia is increasing use of ketamine. In 2008, 86% of global ketamine seizures occurred in Southeast Asia. Ketamine is a veterinary anaesthetic which has not been classified illicit under the Drug Conventions. This makes it widely available for diversion in many countries. In 2009, ketamine use was reported in Australia, Brunei Darussalam, China, Hong Kong (SAR), Indonesia, Malaysia and Singapore. In Hong Kong (SAR) ketamine was reported as the main drug of use. Its use was reported to have increased in 2009 in Brunei Darussalam, China, Indonesia and Malaysia. One reason for its increasing use is that ketamine is cheaper than other drugs such as MDMA.

Apart from ATS, cannabis, heroin, opium and ketamine, several other illicit drugs are used in the region, although to a lesser extent. The most common of these drugs is the benzodiazepine, nimetazepam. Other substances used include benzodiazepams and other prescription drugs and pharmaceuticals, inhalants, new designed drugs (eg Mephadrone, "Spice") and other synthetics (eg "N-Benzylpiperazine, "GHB/GBL."³

II. OVERVIEW OF INTERNATIONAL DRUG CONVENTIONS

The current legal and administrative framework for international drug control is laid out in three international Conventions negotiated under the auspices of the United Nations. This involves a system of control to limit the production, distribution and use of such substances to medical and scientific purposes and prohibition of those forms of conduct for other purposes.

The current international drug control system is based on three complementary conventions:

¹ Bergenstrom A. & Abdul-Quader A. 2010. Injection drug use, HIV and the current response in selected low-income and middle-income countries. *AIDS* 2010, 24 (suppl 3):S20–S29.

² *Ibid.*

³ GBL refers to Gamma-Butyrolactone. GHB refers to Gamma-Hydroxybutyrate. GHB is a clear odourless liquid or white powder usually made into tablets or capsules. GBL is also a liquid and is used as a precursor for the production of GHB. GHB is often used by bodybuilders as an alternative to anabolic steroids.

- The Single Convention on Narcotic Drugs, 1961;
- The Convention on Psychotropic Substances of 1971; and
- The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

The three major international drug control treaties are mutually supportive and complementary. An important purpose of the first two treaties is to codify internationally applicable control measures in order to ensure the availability of narcotic drugs and psychotropic substances for medical and scientific purposes, and to prevent their diversion into illicit channels. Thus, the overall purpose of the UN Drug Control Conventions is to:

- Ensure the availability of useful drugs for medical purposes;
- Prevent drug abuse; and to
- Limit supply and use of drugs exclusively to medical and scientific needs.

The Conventions have been signed and ratified by the majority of UN member states.⁴

The Preambles to the Conventions refer to “health and welfare of mankind” as the motivation for action by the international community. The 1961, 1971 and 1988 Conventions request States Parties to provide, as an alternative or in addition to conviction or punishment, treatment, education, aftercare, rehabilitation and social integration to drug-abusing offenders, whether in prison or in the community.

The 1961 Single Convention on Narcotic Drugs replaced the pre-World War II Opiate, Cannabis and Cocaine Treaties and introduced international control mechanisms for drugs under international control and aims to combat drug abuse by coordinated international action.⁵ There are two forms of intervention and control that work together. First, it seeks to limit the possession, use, trade in, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes. The 1961 Single Convention focuses on import/export control, the system of estimates, the creation of monitoring bodies and the classification of drugs.

While the primary objective of the 1961 Convention is to restrict the use of controlled drugs to “medical and scientific purposes”, its article 38 also obliges governments to promote treatment, aftercare, rehabilitation, and social reintegration for dependent drugs users.⁶

Article 36 sub paragraph 1(b) of the 1961 Single Convention on Narcotic Drugs stipulates that these services may be offered as an alternative or in addition to conviction or punishment.

...when abusers of drugs have committed such offences, the Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration in conformity with paragraph 1 of article 38.

Article 38 of the 1961 Single Convention on Narcotic Drugs provides for the following measures against the abuse of drugs:

“The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends”.

⁴ The Single Convention on Narcotic Drugs, 1961, has 184 parties; the Convention on Psychotropic Substances of 1971 has 183 parties; and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988 has 185 parties to date.

⁵ The 1961 Single Convention came into force in 1964.

⁶ This article, and related provisions, were added to the Single Convention by the amendments of its 1972 Protocol. The official commentary is available at: http://www.unodc.org/documents/treaties/organized_crime/Drug%20Convention/Commentary_on_the_protocol_1961.pdf

"The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of drugs".

"The Parties shall take all practicable measures to assist persons whose work so requires to gain an understanding of the problems of abuse of drugs and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of drugs will become widespread".

The 1971 Convention on Psychotropic Substances establishes an international control system for psychotropic substances.⁷ It responded to the diversification and expansion of the spectrum of drugs of abuse and introduced controls over a number of synthetic drugs according to their abuse potential on the one hand and their therapeutic value on the other. It controls over one hundred psychotropic substances. As is the case with the 1961 Single Convention, the 1971 Convention also focuses on import/export control, the system of estimates, the creation of monitoring bodies and the classification of drugs. The 1971 Convention on Psychotropic Substances also obliges the parties to promote public understanding of drug dependence, train personnel and to conduct research. The 1971 Convention also stipulates that parties are to identify and treat drug dependent persons and to provide access to treatment, care, rehabilitation and social integration, as an alternative, or in addition to, punishment.

The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances⁸ provides comprehensive measures against drug trafficking, including provisions against money laundering and the diversion of precursor chemicals. It provides for international cooperation through, for example, extradition of drug traffickers, controlled deliveries and transfer of proceedings.

Article 3, paragraph 4(d) of the 1988 Convention stipulates that in the case of possession, purchase or cultivation of drugs for personal consumption contrary to the provisions of the 1961 or the 1971 Conventions:

- b) The Parties may provide, in addition to conviction or punishment, for an offence established in accordance with paragraph 1 of this article, that the offender shall undergo measures such as treatment, education, aftercare, rehabilitation or social reintegration.*
- c) Notwithstanding the preceding subparagraphs, in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare.*
- d) The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender.*

Thus, the 1988 Convention enables States to adopt laws focusing on medically appropriate treatment for drug dependence as an alternative to criminal sanctions or in addition to criminal sanctions. This is also the case with the 1961 and 1971 Conventions.

III. UNODC/WHO PRINCIPLES OF DRUG DEPENDENCE TREATMENT

The *UNODC/WHO Discussion Paper: Principles of Drug Dependence Treatment*,⁹ published in 2009, aims to encourage Governments and other partners to take concerted action for the implementation of evidence-based drug dependence treatment services, which respond to the needs of the countries and their populations.

Given the scale of the challenge of problematic drug use and dependence in most societies and the limited financial and human resources available, a clear and coherent approach to planning of drug dependence treatment services is required. There is a need to develop treatment services that can reach the maximum number of individuals and have the greatest impact at lowest cost. This is most likely to be achieved with

⁷ The 1971 Convention came into force in 1976.

⁸ The 1988 Convention came into force in 1990.

⁹ Available at: http://www.unodc.org/docs/treatment/Principles_of_Drug_Dependence_Treatment_and_Care.pdf

broad community-based health care services that can work with individuals in their own communities over longer periods of time.

Scientific evidence indicates that the development of the disease of drug dependence is a result of a complex multi-factorial interaction between repeated exposure to drugs, and a mix of biological and environmental factors. Attempts to prevent or treat drug use and dependence solely through tough penal sanctions for drug users fail because they do not take into account the neurological changes drug dependence has on motivation pathways in the brain.

UNODC and WHO consider drug dependence a multi-factorial health disorder that often follows the course of a relapsing and remitting chronic disease. Effective coordination between the criminal justice system and the health/drug dependence treatment system is necessary to address the problems of drug use and its related crimes. Drug dependence is a preventable and treatable disease, and effective prevention and treatment interventions are available. Therefore, “nothing less” must be provided for the treatment of drug dependence than a qualified, systematic, science-based approach such as that developed to treat other chronic diseases that were considered untreatable some decades ago. The best results are achieved when a comprehensive multidisciplinary approach which includes diversified pharmacological and psychosocial interventions is available to respond to different needs.

Research studies indicate that spending on treatment produces savings in terms of reduction in the number of crime victims, as well as reduced expenditures for the criminal justice system. Drug taking behaviour inside the prison involves more harmful patterns leading to increased risk of transmission of HIV and Hepatitis. The potential for imprisonment to cause harm should not be underestimated. Research has also shown that alternative measures to imprisonment or treatment in prisons or can reduce post release use of drugs and reoffending.

The UNODC/WHO Discussion Paper outlines nine key principles for the development of services for treatment of drug use disorders. It is recognized that in some circumstances resources will be rather limited and priorities in resource allocation need to be set. It is important that in such situations, a response to drug use disorders and the actions suggested by the present document may be progressively and gradually implemented, taking into account the outlined components for each principle as general framework.

A. Principle 1: Availability and Accessibility of Drug Dependence Treatment

1. Components

Many factors contribute to treatment accessibility:

- Geographical accessibility, distribution and linkages
- Timeliness and flexibility of opening hours
- Legal framework
- Availability of low threshold services
- Affordability
- Cultural relevance and user friendliness
- Responsiveness
- Criminal justice system responses
- Gender-sensitiveness of services

B. Principle 2: Screening, Assessment, Diagnosis and Treatment Planning

1. Components

- Screening
- Assessment and diagnosis comprehensive assessment
- The treatment plan

C. Principle 3: Evidence-Informed Drug Dependence Treatment

1. Components

- There is a range of evidence-based pharmacological and psychosocial interventions
- Sufficient duration
- Integration
- Multidisciplinary
- Brief interventions
- Outreach and low-threshold
- Basic services
- Medically supervised withdrawal
- Maintenance medications
- Psychological and social interventions
- Self-help support groups
- Socio-cultural relevance
- Knowledge transfer and ongoing clinical research
- Training of treatment professionals

D. Principle 4: Drug Dependence Treatment, Human Rights, and Patient Dignity

1. Components

- Access to treatment and care
- Discrimination
- The human rights of people with drug dependence

E. Principle 5: Targeting Special Subgroups and Conditions

1. Components

- Adolescents
- Women
- Pregnant women
- People with medical co-morbidities
- People with psychiatric co-morbidities
- Sex-workers
- Ethnic minorities
- Marginalized/street people

F. Principle 6: Addiction Treatment and the Criminal Justice System

1. Components

- Diversion schemes from criminal justice system into treatment
- Human rights principles
- Continuity of services
- Continuous care in the community
- Neither detention nor forced labour

G. Principle 7: Community Involvement, Participation and Patient Orientation

1. Components

- Patient active involvement
- Accountability to the community
- Community-oriented interventions
- Mainstreaming drug dependence treatment in health and social care
- Interventions
- Linkages
- NGOs

H. Principle 8: Clinical Governance of Drug Dependence Treatment Services

1. Components

- Service policy
- Treatment protocols
- Qualified staff
- Supervision
- Financial resources
- Communication structures
- Monitoring systems
- Updating services

I. Principle 9: Treatment Systems: Policy Development, Strategic Planning and Coordination of Services

1. Components

- Treatment policy
- Link to prevention
- Situation assessment
- Coordination between different sectors (health, social welfare, criminal justice) and appropriate balance between specialized services and primary care
- Continuum of care
- Multidisciplinary approach
- Capacity building
- Quality assurance, monitoring and evaluation