

IDPC Advocacy Note

Abstinence-based drug dependence treatment is not a substitute for proven HIV prevention measures

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Summary

In recent years, many governments and international agencies have sought to support of the expansion and improvement of treatment services for people dependent on drugs. These initiatives, most notably the joint UNODC/WHO Joint Programme on Drug Dependence Treatment and Care,¹ are very welcome in their commitment to improving the quality and availability of drug dependence treatment services, as well as the promotion of human rights compliant and evidence-based models of treatment and support for those people who use drugs who need it.

However, the International Drug Policy Consortium (IDPC) and its members are concerned at the tendency of some commentators to suggest that the wider availability of treatment services for people dependent on drugs can be promoted as an alternative strategy for preventing the transmission of HIV, and other drug related health problems. This perspective is incorrect, and can be highly damaging – while at an individual level, abstinence from drug use can of course be an effective way of reducing health risks, global experience of over 25 years of harm reduction has clearly shown that national strategies based on abstinence-only approaches are ineffective at curbing drug related HIV epidemics. Abstinence and harm reduction strategies are often presented as competing alternatives, whereas in a fully comprehensive response to drug dependence, they should operate as mutually supporting elements of an integrated system.

It is important that policy makers and professionals remember these lessons, and focus on promoting the agreed UNAIDS prevention strategy, which clearly calls for the widespread provision of a wide and mutually reinforcing range of public health activities, including needle and syringe programmes, and opioid substitution treatment. In particular, UNODC, as the lead co-sponsor within the UNAIDS family on this issue, needs to be clear in its recommendations to governments that the implementation of the agreed HIV prevention package is essential to prevent and reverse epidemics amongst people who inject drugs, and that the expansion of abstinence-oriented treatment does not constitute an alternative strategy. The recent UNAIDS paper “How to halve HIV transmission among people who inject drugs by 2015”, launched at the 55th Session of the Commission on Narcotic Drugs, is unequivocal about the need for NSP and OST as the two most effective interventions for preventing HIV among people who inject drugs.²

¹ [http://www.unodc.org/docs/treatment/WHO - UNODC Joint Programme Brochure.pdf](http://www.unodc.org/docs/treatment/WHO_-_UNODC_Joint_Programme_Brochure.pdf)

² Joint United Nations Programme on HIV and AIDS (2012), *How to halve HIV transmission among people who inject drugs by 2015*

Drug dependence treatment

An estimated 250 million people worldwide use at least one of the drugs controlled under the United Nations Conventions. It is important to recognise that only a small proportion of them, an estimated 10 to 15%, can be classified as dependent and in need of treatment.³ However, even in the most developed countries, only a small proportion of people dependent on drugs get access to good quality specialist treatment services. In many countries with high rates of drug dependence, these services are either non-existent, accessible only to those with the ability to pay, or are based on coercive and punitive approaches that breach the basic human rights standards of dignity, privacy and self-determination.

IDPC is supportive of attempts to expand and improve treatment provision, as an effective strategy for reducing the crime, health and social harms associated with drug dependence. We have produced guidance on the development of evidence-based and integrated drug dependence treatment systems,⁴ and are working with several governments to promote these principles in individual countries. We encourage policy makers to structure their drug dependence treatment services as an integrated system of care and support, within which three elements are carefully defined and planned – 1) the identification and targeting of the highest priority groups; 2) the provision of interventions that are effective in changing behaviour; and 3) the availability of processes to facilitate the reintegration of people who use drugs into the community through employment, accommodation and positive family relationships. We make it clear that the decision of an individual to enter into treatment should be voluntary. As the UN “Joint Statement on Compulsory Detention and Rehabilitation Centres”⁵ makes clear, forced or compulsory treatment breaches medical ethics and human rights norms, and has been shown to be ineffective in achieving lasting recovery.

We also strongly advise that these mechanisms, designed to support people dependent on drugs in addressing their dependence problems, need to be carefully integrated with programmes that minimise the health risks associated with drug use, in particular the proven strategies for preventing the transmission of HIV among people who use drugs. These harm reduction approaches have been developed and refined across the world over decades and, through rigorous monitoring and evaluation, have proven to be effective at preventing and reversing drug-related epidemics. These strategies are fully accepted and promoted by the responsible global authorities, and are described in the joint “WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users”⁶, and the UNAIDS 2011-2015 Strategy “Getting to zero”⁷. Governments or health professionals that refuse to implement these measures are contravening medical best practice and the agreed global scientific consensus.

Despite the evidence, many governments and medical professionals continue to resist the implementation of these proven strategies. Central to the harm reduction and public health approach is the idea that health protection services should be provided to people who inject drugs irrespective of whether they are immediately willing or able to stop using drugs. Services such as

³ United Nations Office on Drugs and Crime (2011), *World drug report* (Vienna: United Nations Office on Drugs and Crime), <http://www.unodc.org/unodc/en/data-and-analysis/WDR-2011.html>

⁴ ‘Chapter 3.3: Drug dependence treatment’, In International Drug Policy Consortium (2012), *IDPC Drug Policy Guide, Second Edition*, <http://idpc.net/publications/2012/03/idpc-drug-policy-guide-2nd-edition>

⁵ Joint statement - Compulsory drug detention and rehabilitation centres, http://www.unescobkk.org/fileadmin/user_upload/hiv_aids/Images/tt_news_photos/2012_tt_news_docs/JC2310_Joint_Statement6March12FINAL_En.pdf

⁶ World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2009), *WHO, UNODC, UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* (Geneva: WHO), http://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf

⁷ Joint United Nations Programme on HIV/AIDS (2010), *2011-2015 Strategy – Getting to zero*, http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2034_UNAIDS_Strategy_en.pdf

needle and syringe programmes (NSPs) and opioid substitution treatment (OST) are effective at reducing risks of HIV infection associated with injecting. The resistance to these services usually comes from a political or professional discomfort with providing services that are seen as tolerating or facilitating continued drug use. However, numerous reviews and studies have shown that NSPs and OST do not lead to increased levels of drug use and, conversely, the absence of these services does not lead to a reduced prevalence of use.⁸

Policy approaches that have only focused on abstinence-based forms of treatment and/or on punitive approaches towards people who use drugs have consistently been ineffective in preventing or reversing drug-related HIV outbreaks. Those countries that have put their faith in these strategies have experienced severe problems with high rates of HIV prevalence amongst people who inject drugs. In Europe in the 1980s, when HIV prevalence amongst people who use drugs first emerged, countries like the UK, Switzerland and the Netherlands rapidly introduced widespread harm reduction measures, and have since seen HIV rates amongst people who use drugs remain consistently low. Countries like Spain and France, however, resisted the introduction of these measures for several years, and experienced worrying levels of drug-related HIV infection until their policies were reversed in the 1990s. Countries that have consistently failed to implement harm reduction strategies, such as Russia and Thailand, are now inevitably experiencing the highest rates of drug-related HIV prevalence in the world.⁹

All too often, abstinence and harm reduction strategies are presented as competing alternatives, whereas in a fully comprehensive response to drug dependence, they should operate as mutually supporting elements of an integrated system. Within such a system, outreach and NSPs are an effective way of engaging with marginalised users, and OST provides the means of engaging with, and stabilising the lives of, street users, so that they have the space to make decisions about their use and potential recovery. In the absence of these services working within the reality of street drug use, drug dependence treatment strategies will always be limited in their impact, working only with those who are willing and able to achieve abstinence immediately – at any one time, this will only be true for a minority of users.

The academic and scientific community, national governments, and international agencies have a responsibility to promote this balanced and integrated approach. Of most importance is the position taken by UNODC. As lead co-sponsor within UNAIDS for promoting and funding best practices in HIV prevention, treatment and care amongst people who use drugs, the UNODC is responsible for promoting the globally agreed HIV prevention strategy, including the clear call for the scaling up of NSPs and OST in all countries facing widespread drug injecting amongst their citizens. We are concerned that this clarity of leadership is currently absent and, even worse, some of the positive work that UNODC is doing in the field of drug dependence treatment is being presented as an alternative to the UNAIDS strategy that it is meant to promote.

For instance, a UNODC sponsored conference in Kiev in May 2012 includes in its introduction the statement that: “Preventing and treating drug use disorders can significantly reduce the demand for illicit drugs and help prevent drug-related harm. *Thus drug strategies aiming at drug demand reduction represent the rational response to communicable blood-borne diseases such as HIV and Hepatitis*”.¹⁰

⁸ See, for example: European Monitoring Centre for Drugs and Drug Addiction (2010), *Harm reduction: evidence, impacts and challenges* (Lisbon: EMCDDA), <http://www.emcdda.europa.eu/publications/monographs/harm-reduction>; Institute of Medicine of the National Academies (2006), *Preventing HIV infection among injecting drug users in high risk countries: An assessment of the evidence* (Washington DC: The National Academies Press), <http://www.iom.edu/Reports/2006/Preventing-HIV-Infection-among-Injecting-Drug-Users-in-High-Risk-Countries-An-Assessment-of-the-Evidence.aspx>

⁹ Global Commission on Drug Policy (2011), *War on drugs* (Rio de Janeiro: Global Commission on Drug Policy), http://www.idpc.net/sites/default/files/library/Global_Commission_Report_English.pdf

¹⁰ International High-Level Conference on Comprehensive and Integrated Approach to Prevention & Treatment of Drug Dependence and related HIV/AIDS “Ukrainian Society and Drugs: Building a New Strategic Approach”, Kyiv, 21-23 May 2012 (draft agenda), <http://narko.gov.ua/komnarko/uk/publish/article/97575>

This statement is incorrect, and directly contradicts the global evidence assembled over the last 25 years, and the official positions of the WHO and UNAIDS. It is a particularly dangerous statement in Eurasia, a region where the dominant driver of HIV transmission is the injection of drugs with non-sterile equipment. HIV rates amongst people who inject drugs are as high as 10% in most countries in the region, and 42% of newly diagnosed HIV cases are reported to be acquired through unsafe injecting drug use.¹¹ The provision of effective HIV prevention services in the region is also particularly low, suffering from the lack of political and scientific support¹² that the UNODC should be challenging.

We have ample experience of the health and social costs to communities and governments of unchecked HIV epidemics amongst people who use drugs, and we know what we need to do to prevent them. A refusal to take the necessary actions to reduce infections and save thousands of lives – through a misguided commitment to zero tolerance policies or abstinence-only treatment models – is a mistake that will take decades to put right. The HIV virus does not respect borders or ideology – we have the tools to tackle it, we just need the vision and leadership to use them.

Recommendations¹³

- National governments should develop explicit plans to expand the availability, and improve the quality and effectiveness of drug dependence treatment.
- National systems of response to dependent and injecting drug use should integrate proven harm reduction measures (i.e. needle exchange and opioid substitution treatment), as well as efforts to support people to become abstinent.
- As only a small proportion (10 to 15%) of people who use drugs are dependent and in need of treatment, national drug dependence treatment systems should target interventions at those individuals, rather than trying to encompass all people who use drugs.
- All drug dependence treatment services should be delivered in full compliance with human rights standards, which precludes the implementation of compulsory or coerced treatment.
- The definition of which people who use drugs meet criteria for dependence should be based on globally agreed criteria.¹⁴
- International bodies (UNODC, WHO, European Union, CICAD) should bring together their work on developing standards and best practices in drug dependence treatment to agree

¹¹ Eurasian Harm Reduction Network (2012), *Quitting while not ahead - The Global Fund's retrenchment and the looming crisis for harm reduction in Eastern Europe & Central Asia*, http://www.harm-reduction.org/images/stories/library/quitting_while_not_ahead.pdf

¹² Latypov, A. & Bidordinova, A. (2012), *IDPC Briefing Paper - Opioid substitution therapy in Eurasia: How to increase the access and improve the quality* (London: IDPC), http://dl.dropbox.com/u/64663568/library/IDPC-briefing-paper_OST-in-Eurasia.pdf

¹³ For more information, please refer to 'Chapter 3.3: Treatment for drug dependence' in International Drug Policy Consortium (2012), *IDPC Drug Policy Guide*, <http://dl.dropbox.com/u/64663568/library/IDPC%20Guide%20HTML/Chapter-3.3.pdf>

¹⁴ See the WHO International Classification of Diseases, ICD-10: "A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. The dependence syndrome may be present for a specific psychoactive substance (e.g. tobacco, alcohol, or diazepam), for a class of substances (e.g. opioid drugs), or for a wider range of pharmacologically different psychoactive substances". <http://apps.who.int/classifications/icd10/browse/2010/en/#F12.2>

and disseminate simple and accessible guidance to national governments on how to develop effective systems.

- National governments should explicitly use this guidance to ensure that their interventions are evidence-based, humane, and delivered by suitably qualified and supervised practitioners.
- International bodies must explicitly disseminate and promote the agreed package of HIV prevention measures, as articulated in the UNAIDS strategy, that represent global scientific consensus. This applies particularly strongly to the UNODC which, as the lead UNAIDS co-sponsor on this subject, has the highest responsibility to promote this evidence based package to national governments.

International Drug Policy Consortium

The International Drug Policy Consortium is a global network of non-government organisations and professional networks that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert consultancy services to policy makers and officials around the world.

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