United Nations E/CN.7/2003/L.7/Rev.1

Economic and Social Council

Distr.: Limited
10 April 2003

English
Original: English and French

Commission on Narcotic Drugs
Forty-sixth session
Vienna, 8-17 April 2003
Agenda item 6 (d)
Implementation of the international drug control treaties: other matters arising from the international drug control treaties

Belgium, Czech Republic, Greece, Ireland, Slovakia and Switzerland: draft resolution

Minimum requirements for medically and psychosocially assisted treatment of opiate-dependent[1] persons

The Commission on Narcotic Drugs,

Recognizing the large number of opiate-dependent persons and the significant number of them receiving treatment,

Re-emphasizing that medically assisted treatment is a practical tool for use in achieving concrete goals in relation to the reduction of harm and long-term risks,

Taking note that medically assisted treatments are most effective if they are supported by adequate psychosocial treatments,

Taking into account the extensive scientific literature on the usefulness of such treatment,

Reaffirming that substitution treatment should be considered part of medically assisted pharmaceutical treatment and should be used to maintain opiate-dependent persons in long-term medical treatment in order to reduce the consumption of illicit drugs and the risk of transmitting infectious diseases, to improve mental and physical health and to reduce drug-related crime, with a view to achieving abstinence, when possible,

Mindful of the need to facilitate access by patients to maintenance treatment for major opiate addiction,

[1] "Dependent" is used here to mean addicted.

V.03-82937 (E)

Mindful also of the need to ensure continuity of treatment for such patients,

Recalling the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol,[2] in particular article 38, on measures against the abuse of drugs,

Taking into consideration the conclusions and recommendations adopted by the Conference on Control of Narcotic Drugs and Psychotropic Substances in Europe, organized jointly by the Pompidou Group of the Council of Europe and the International Narcotics Control Board in Strasbourg, France, in October 2002,

Taking note of the European Union Action Plan to Combat Drugs (2002-2004), which states that States should provide a wide variety of treatment services for drug users and allocate adequate resources to drug treatment,

Taking note of the *Report of the International Narcotics Control Board*[3] *for 2002*, in paragraph 102 of which the Board called upon the Governments of States where opioids were used for substitution treatment to take measures to reduce their diversion into illicit channels,

Acknowledging that the present resolution may be relevant only to States providing medically and psychosocially assisted treatment or planning to introduce such treatment,

1. *Notes with satisfaction* that international bodies and States party to the international drug control treaties have taken into account the problems involved in making available the medically and psychosocially assisted treatment of opiate-dependent persons;

2. *Recommends* that the minimum requirements for the medically and psychosocially assisted treatment of opiate-dependent persons annexed to the present resolution be implemented, in order to enhance the effectiveness of opioid-assisted treatment.

3. *Urges* the States involved to consider implementing the recommendations on the medically and psychologically assisted treatment of opiate-dependent persons;

4. *Invites* the United Nations International Drug Control Programme, the World Health Organization and other relevant regional organizations to establish and publish worldwide guidelines,[4] in order to assist the States involved.

---

[2] United Nations, *Treaty Series*, vol. 976, No. 14152.

[3] *Report of the International Narcotics Control Board for 2002* (United Nations publication, Sales No. E.03.XI.1).

[4] Based on the 1989 World Health Organizaton document edited by M. Gossop, M. Grant and A. Wodak (*The Uses of Methadone in the Treatment and Management of Opioid Dependence* (WHO/MNH/DAT/89.1)).

Annex

Minimum requirements for the medically and psychosocially assisted treatment of opiate-dependent persons

A. Common recommendations for treatments

1. Inclusion criteria, as well as exclusion criteria, should be defined before providing any kind of treatment to drug users.

2. A wide range of registered medical preparations should facilitate the selection of the most suitable modality of treatment and allow for the introduction of an individualized and relevant treatment plan. Long-acting treatment medications should be given preference because of their pharmacological advantages.

3. Medically assisted treatment must be provided in conjunction with psychosocially assisted treatment, which, in turn, should be readily available and of high quality.

4. Provisions should be made to ensure the necessary referrals to health and social welfare services, whenever required.

5. Informed consent to treatment should be sought from patients.

6. A treatment plan should be designed after treatment intake, in agreement with the patient. The treatment plan should be reviewed at predefined intervals in the first phases of treatment and whenever necessary thereafter.

7. Treatment should be provided in adequate doses to cover the individual needs of patients and should be associated with psychosocial treatment.

8. Measures should be taken to reduce to a minimum the diversion or misuse of pharmaceutical preparations involved in medically assisted treatments:

(a) In order to avoid duplication of treatment, medical records should be accessible at the national or regional level to medical practitioners authorized to provide such treatment in accordance with national laws and regulations;

(b) Agreement between the patient (regarding compliance with rules and controls), the doctor (regarding adequate dosage and psychosocial support) and the pharmacist (regarding mandatory registration and delivery) is desirable.

B. Recommended treatment guidelines

9. Special reception, assessment (medical, social and psychological) and referral services should be made available whenever possible to provide all opiate-dependent persons applying for treatment with appropriate information, guidance and referral to the modality best suited to the individual.

10. There should be an adequate combination of training and experience for those providing medically assisted treatment, such as special diploma courses and a minimum length of experience in the field.

11. There should be evidence-based consensus on the adequate dosage and pharmaceutical form of the specific substitution drugs (such as methadone and buprenorphine) to be used in the treatment.

12. Only medical preparations authorized for such therapeutic use should be used.

13. There should be consensus to avoid risk associations (for example, in the case of benzodiazepine).

14. Compliance with treatment should be ensured through practices such as physical examination, drug abuse testing, controlling the dosage level and administration of drugs under the supervision of care providers.

15. Standardized data should be collected on the treatment process regarding the patient and the medicinal drug, with due respect for confidentiality.

16. Care should be taken to ensure that treatment interventions correspond to the needs of the particular phase of the treatment—the starting phase, the stabilization phase or the rehabilitation phase. During the starting phase, the patient usually struggles to reduce his or her illicit drug use, begins to reduce the intensity of the psychiatric, medical and/or social problems associated with his or her opiate dependence, tries to find a dosage level that suppresses withdrawal symptoms and blocks the effects of co-administered illicit opiates. In the stabilization phase, the dosage must be stabilized in order that the patient can start to become socially reintegrated.

C. Treatment outcome indicators

17. Most of the following indicators could be derived from the data collected on the treatment process (other indicators such as the relapse ratio could also be used):

(a) Illicit drug use;

(b) Polydrug abuse;

(c) Psychiatric morbidity (risk factor and comorbidity);

(d) Somatic morbidity (human immunodeficiency virus and hepatitis C virus);

(e) Mortality;

(f) Criminality ratio;

(g) Social integration.