Technical Briefs
on amphetamine-type stimulants (ATS)

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World Health Organization
Western Pacific Region

Principles of prevention and treatment for the use of amphetamine-type stimulants (ATS)

The principles of treatment for ATS use are examined in the light of the principles of drug dependence treatment developed by WHO/UNODC in 2008. Recommendations were adapted to the needs of ATS users in Asia and the Pacific.

Amphetamine-type stimulant (ATS) users exhibit a complex spectrum of behaviours ranging from occasional/recreational use to heavy, problematic injecting and polydrug use. The vast majority are either experimental or "recreational" users who use drugs occasionally on weekends or at parties, or intermittent or "binge" users who use a lot of drugs for a few days consecutively but not regularly or consistently. Only a minority, estimated at around 3%, of methamphetamine users can be characterized as regular users.[1] However, research indicates that the number of dependent users as defined by the International Classification of Diseases (ICD)-10[2] is larger and estimated at around 11%.[3] Additionally, ATS are regularly, legally and beneficially used in medical practice, especially for the treatment of attention deficit disorders and obesity. (Adderall [dextroamphetamine/amphetamine] was approved for unrestricted use for the treatment of attention deficit hyperactivity disorder [ADHD] by the US Federal Drug Administration [FDA] in March 1996.)

Although only a minority of ATS users are technically drug dependent, the principles of drug dependence treatment[4] are also applicable to ATS users since they provide an overall scientific, ethical and legal framework for all drug treatment. To date, law enforcement and supply reduction approaches have characterized much of the response to ATS users in the Asia–Pacific region.[5] This type of response frequently results in compulsory incarceration of ATS users in residential centres; an intervention for which there is no evidence of effectiveness.[6]

1 Turning Point Alcohol and Drug Centre. *Clinical Treatment Guidelines for alcohol and drug clinicians (14): methamphetamine dependence and treatment.* Victoria, Australia, 2007. (http://www.turningpoint.org.au/library/cg_14.pdf. accessed on 01 January 2011).

2 World Health Organization. *International Statistical Classification of Diseases and Related Health Problems (10th revision)*. Geneva, WHO, 2007.

3 Anthony JC et al. Comparative epidemiology of dependence on tobacco, alcohol, controlled substances, and inhalants: basic findings from the National Comorbidity Survey. *Experimental and Clinical Psychopharmacology*, 1994, 2:244–268.

4 UNODC/WHO. *Principles of drug dependence treatment: discussion paper*. March 2008. (http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf, accessed on 02 January 2011).

5 Global SMART Programme. *Patterns and trends of amphetamine-type stimulants and other drugs in East and South-East Asia (and neighbouring regions)*. UNODC, 2009 (http://www.unodc.org/documents/eastasiaandpacific//2009/11/ats-report/2009_Patterns_and_Trends.pdf, accessed 02 January 2011).

6 The Nossal Institute for Public Health, Open Society Institute Public Health Program. *Detention of methamphetamine users in Cambodia, Laos and Thailand*. Open Society Institute, 2010. (http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/detention-as-treatment-20100301/Detention-as-Treatment-20100301.pdf, accessed 01 January 2011).

The following is a brief summary of the principles of drug dependence treatment, with comments on how and why they should be applied to ATS users. The diversity of ATS users and their varied and complex behaviours require a multifaceted response. The interventions recommended must thus be adapted to the realities of the patterns and pharmacology of ATS use in a particular setting.

Principle 1: Availability and accessibility of ATS dependence treatment in the Asia–Pacific region

Treatment services for ATS users should be geographically accessible and located where ATS users live or congregate. Access to such services should be provided through multiple entry points. Outreach services are needed to reach "hidden" populations of ATS users, and treatment services should be provided according to convenience, i.e. have flexible opening hours. The attitude of staff at treatment services should be welcoming and non-judgemental, and sensitive to gender issues. Services should be responsive to the client's multiple needs; the needs of ATS users should be taken into consideration in service design and implementation.

The majority of ATS users are not drug dependent and therefore do not need extensive treatment. However, all users are at risk for experiencing harmful consequences (e.g. sleeplessness, agitation, inability to fulfil normal social functions, etc.) and may engage in unsafe sex while intoxicated, risking infection with HIV or hepatitis B and C.[7] Services for ATS users need to be guided by the intensity and frequency of use. They should be designed to meet the needs of this heterogeneous group of users by developing innovative approaches to make services relevant and attractive. ATS users, whether dependent or not, are routinely detained in residential centres, often a form of compulsory detention.[8]

Existing drug dependence services in the region focus on opioid users and do not cater adequately to the specific needs of ATS users. There is a lack of professional expertise and counselling training in the region, and little experience in dealing with the psychosocial and mental health problems of ATS users.

Principle 2: Screening, assessment, diagnosis and treatment planning

In the absence of services in the Asia–Pacific region, very few ATS users are screened, assessed, diagnosed or assisted with a treatment plan. If apprehended by law enforcement agencies, the majority are taken directly to detention centres, whether or not they have been using drugs regularly or heavily.[9] In some countries, the compulsory centres cater almost exclusively to ATS users (e.g. Cambodia, Lao People's Democratic Republic, Thailand), and little or no voluntary facilities are available.

7 Centers for Disease Control and Prevention (CDC), Department of Health and Human Services. *Methamphetamines use and the risk for HIV/AIDS: Fact Sheet.* Atlanta, CDC, January 2007. (www.cdc.gov/hiv/resources/factsheets/meth.htm, accessed 20 May 2010).

8 WHO, UNAIDS, UNODC, The Global Fund, ANPUD. *A strategy to halt and reverse the HIV epidemic among people who use drugs in Asia and the Pacific 2010–2015.* Geneva, WHO, 2010:16. (http://www.searo.who.int/LinkFiles/Publications_Harm_Reduction_Strategy2010-2015.pdf, accessed 01 January 2011).

9 WHO. *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: an application of selected human rights principles.* Manila, WHO Western Pacific Region, 2009.

Principle 3: Evidence-informed treatment for ATS dependence

There are numerous evidence-based psychological interventions. *No single drug dependence treatment intervention fits all ATS users*. Not all ATS users necessarily require specialized treatment services. For example, moderate cases may be treated in primary health-care settings. Ideally, treatment services should be multidisciplinary and include expertise in different areas to deal with the heterogeneity of ATS-using populations. ATS users with co-morbid psychiatric problems will need specialized care but those who use ATS experimentally and occasionally could be offered brief interventions. Outreach and low-threshold interventions should be used to reach clients who do not attend services. Medically supervised withdrawal is recommended for users who choose abstinence. However, *detoxification* alone is not an effective drug treatment method, as it is a short-term intervention that deals only with removal of the drug and does not address other needs. Relapse following detoxification is extremely common. Nevertheless, ready access to detoxification should be part of the range of interventions available as it may help in introducing some ATS users to other interventions.

Current ATS "treatment" approaches in the Asia–Pacific region are predicated upon the objective of eliminating the problem of ATS use from society. However, "wars on drugs", incarceration of ATS users in military or police establishments or prisons are not based on evidence.

Excessive use of ATS requires a similar approach as that for the excessive use of other substances. A multidisciplinary approach is indicated to deal with the complexity of drug-use behaviour. However, more research is needed in order to determine which specific interventions are most applicable to ATS users. To date, there are no approved pharmacotherapeutic/substitution treatments for ATS use. Principle 3 is otherwise applicable to ATS users who are expected to benefit from the whole range of community-based and low-threshold approaches to drug treatment, combined with counselling and social reintegration and rehabilitation. More research is needed in the Asia–Pacific region to determine which interventions are most effective in the local socioeconomic and cultural context.

In order to develop evidence-based approaches suitable for the Asia–Pacific region, the following key issues should be considered: Who are the drug users in the community? Which of the amphetamines do they use? How do they use them? How often, where and with whom do they use these? What are their social and economic circumstances? How do ATS affect them? Do they attend emergency departments? Do they overdose? Do they experience psychotic symptoms and how and by whom are they treated?

Principle 4: Treatment for ATS dependence, human rights and patient dignity

All approaches to the treatment of ATS use should comply with human rights obligations. The human rights of people with ATS dependence must never be compromised. This includes responding to the right to enjoy the highest attainable standards of health and well-being and ensuring that ATS users are not subjected to discrimination. Inhuman or degrading practices and punishment should never be part of the treatment for ATS dependence. All drug treatment should therefore be voluntary. Only in an exceptional crisis situation such as high risk to self or others should compulsory treatment be considered, and only as a last resort. To ensure that this principle is upheld, ATS treatment must be evidence based and provided by professionals who understand the complexity of ATS use and dependence.

Concerns about human rights and patient dignity are pertinent where ATS use is concerned. Involuntary detention in compulsory centres for drug users is common in Asia.[8] Treatment should always be voluntary and provided only with the consent of the drug user, and not, as frequently happens in the Asia region, either when arrested by the police or solely at the request of the user's family. Little "treatment" is in fact available in these compulsory residential centres and independent evidence has emerged about human rights violation in some of these facilities.[9,10]

Principle 5: Targeting special subgroups and conditions

Several subgroups within the larger population of individuals affected by ATS use require special consideration and specialized care. These include adolescents, women (especially pregnant women), people with medical and psychiatric co-morbidities, entertainment/sex workers, ethnic minorities, refugees and displaced people, as well as socially marginalized individuals. A person may belong to more than one of these groups and have multiple needs.

10 Human Rights Watch. *"Skin on the Cable": the illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia.* Cambodia, Human Rights Watch, 2010. (http://www.unhcr.org/refworld/country,,,,KHM,,4b61771b2,0.html, accessed 01 January 2011).

Existing research about the patterns and extent of ATS use in the Asia–Pacific region suggests that certain population groups are more likely to use ATS than others, and are more vulnerable to negative consequences, thus making the application of this principle pertinent.

Research[11] indicates that adolescents are particularly vulnerable to ATS use, as are men who have sex with men (MSM), male and female entertainment/sex workers and some prisoners. Besides the vulnerable populations mentioned above, special interventions are also needed in the region for users who are at risk for becoming infected, or who are infected, with HIV and/or hepatitis C.[12,13,14]

Principle 6: All treatment services for ATS dependence should seek an alliance with the criminal justice system

Many people are incarcerated for offences committed under the influence of ATS or motivated by the need for money to buy ATS and other substances. It is crucial that drug laws are implemented humanely, respecting the right of ATS users to due process and ensuring that users are not punished along with drug traffickers. It is recommended that, wherever possible, ATS-dependent people apprehended by the criminal justice system should be referred to treatment as an alternative to incarceration. For those who have broken the law and are required to serve a prison sentence, counselling and treatment for ATS use should be made available while in prison or detention and after release. There is no scientific evidence for either detention or forced labour to be effective in the treatment of ATS use disorders.

An examination and revision of drug policies on the use of ATS in the Asia–Pacific region is needed. The criminalization of ATS use is a problem for public health. At the community level, closer collaboration with the police will help facilitate and improve access to services by ATS users who need help and who otherwise may be reluctant to come forward because by doing so they run the risk of being apprehended and taken to jail or to compulsory treatment centres. Social/community pressure to "do something about drugs" encourages law enforcement authorities to detain ATS users, or those suspected of using ATS, on the basis of flimsy evidence of illegal drug use.

ATS users often have a strained relationship with law enforcement and the criminal justice system. Community police intent on applying the law as they understand it often impede harm reduction services that are promoted and authorized by their own ministry of health.

11 Methamphetamine. *Prevention Research Quarterly: Current evidence evaluated*, 2008, 24:2. (www.druginfo.adf.org.au)

12 National Institute on Drug Abuse (NIDA). Research Report Series: Methamphetamine Abuse and Addiction. *Are methamphetamine abusers at risk for contracting HIV/AIDS and hepatitis B and C?* Bethesda, US Department of Health and Human Services, National Institutes of Health, revised September 2006. (http://www.nida.nih.gov/researchreports/methamph/methamph5.html#hiv, accessed 01 January 2011).

13 Response Beyond Borders. *The 1st Asian consultation on the prevention of HIV related to drug use*. Goa, India, 28–31 January 2008. (http://www.aidsportal.org/Article_Details.aspx?ID=5985, accessed 01 January 2011).

14 WHO, UNAIDS, UNODC, The Global Fund, ANPUD. *A strategy to halt and reverse the HIV epidemic among people who use drugs in Asia and the Pacific 2010–2015.* Geneva, WHO, 2010:54–55.

Principle 7: Community involvement, participation and patient orientation

A community-based response to ATS use and dependence can support and encourage behavioural changes directly in the community. However, to achieve this, the patient's active involvement in their treatment is advocated and both the community and service users should play an active part in shaping the service. The community should play a key role in providing a supportive environment for the treatment of ATS use.

Community-based interventions rather than incarceration have been shown to be an effective approach to the treatment of ATS use. The need to mobilize community resources to prevent ATS use and assist users is thus critical. The "wars on drugs" in several Asian countries have led communities to support law enforcement and incarceration rather than providing support and an enabling environment for public health and humane responses to the problems associated with ATS use. The voice of ATS users is almost never heard. An Asian Network of People who Use Drugs (ANPUD) has been established in the region[15] but so far has not paid specific attention to the need for treatment services for ATS dependence.

Principle 8: Clinical management of treatment services for ATS dependence

A treatment service for ATS dependence requires an accountable, efficient and effective method of clinical management that facilitates the achievement of its goals. Service organization needs to reflect current research evidence and be responsive to the needs of service users. Its policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administrative staff and the target population. It is necessary to keep abreast of scientific developments and the changing situation in the community, and update the service accordingly.

New services for ATS dependence are yet to be set up and existing services must adapt to the needs of ATS users. This means that greater attention should be paid to ATS users experiencing acute intoxication or withdrawal, or those who have mental health problems. Methodologies to attract ATS users to treatment services should be developed.

Principle 9: Treatment systems: policy development, strategic planning and coordination of services

A systematic approach is needed to the problems of ATS users and to identify those in need of treatment. Planning and implementing services requires a logical, step-by-step sequence that links policy to needs assessment, treatment planning, implementation, and monitoring and evaluation of the service. Treatment services should be linked to prevention services, and keep abreast of the changes in the ATS use situation in the community to facilitate understanding of the needs of patients. It is critical that the service coordinate with other governmental and nongovernmental agencies in the community on a regular and ongoing basis, and continuously monitor and evaluate its own service provision.

15 Established in October 2009 following the Goa Declaration of the Conference *"Response beyond Borders"*. See reference 13 for details. (http://www.aidsportal.org/Article_Details.aspx?ID=5985, accessed 01 January 2011).

To date, ATS users have received scant attention in national drug policies in Asia and the Pacific, and few services are directed to their special needs. Community-level assessment of ATS use needs to be conducted to determine what services are needed. So far, there is little evidence of strategic planning or coordination with existing drug services. It will be important to link and integrate ATS services with primary health services and with community-based nongovernmental organizations that offer outreach and peer education services. The majority of users will not require specialist health services.

In summary

Overall, the principles of drug dependence outlined above are applicable to all ATS users, including those who are not technically "drug dependent". Key concepts include the right to health, ensuring access to treatment when needed, and a respect for the patient's human rights by ensuring that treatment is always evidence-based, voluntary and not coercive.

The four Technical Briefs on Amphetamine-type Stimulants were designed by the WHO Regional Office for the Western Pacific in response to the demand from Member States and civil society organizations working with people who use drugs in the Region. They are intended to provide guidance and technical assistance.

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