HELSINKI CITIZENS' ASSEMBLY VANADZOR

PECULIARITIES OF POLICY APPLIED IN RELATION TO DRUG USERS IN ARMENIA. MAIN GAPS AND NEED FOR AMENDMENTS




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The goal of the current study is to analyze the policy applied in relation to drug users in the Republic of Armenia, to assess the efficiency of the policy, to draw parallels with the principles put forth by international organizations and expertise of other countries, to evaluate the opportunities of introduction and application of international best practice in the Republic.

During the analysis all the RoA legal acts on drug users have been thoroughly studied, their compliance with the principles recommended by international reputable organizations, such as United Nations Office on Drugs and Crime, and World Health Organization, has been estimated. The practice of other countries, namely, CIS and EU countries as well as the USA, Australia and Canada has been observed.

The current report is a useful source of information and analysis for both state agencies and NGOs conducting activities in the field of drugs and treatment of drug addiction.

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Contents

LIST OF ACRONYMS

NA	National Assembly
WHO	World Health Organization
USA	United States of America
CIS	Commonwealth of Independent States
EU	The European Union
IRI	Islamic Republic of Iran
USSR	Union of Soviet Socialist Republic
GDFOC	**G**eneral Department of Fight against Organized Crime
NGO	Non-governmental organization
RA	Republic of Armenia
ICD	International Classification of Diseases
AIDS	Acquired Immune Deficiency Syndrome
UN	United Nations
HIV	Human Immunodeficiency Virus
SNCO	State Non-Commercial Organization
CJSC	Closed Joint-stock Company
DF	Detention Facility
DD	Department of Detention

IMPORTANCE OF THE ISSUE AND ACTUALITY OF STUDY

Pursuant to the data of Monitoring Centre on Drugs and Drug Addiction, "National Institute of Healthcare after academic S. Avdalbekyan" CJSC under the RA Ministry of Health, the number of persons registered by the Republic's narcological services on the grounds of drug use constituted 5.357 as of December 31, 2014. Whereas, the number of persons registered on the basis of drug use was 4.922 as of the same period in 2013. The number totaled 4332 in 2012, 3893 in 2011 and 2751 in 2010, respectively. [1]

The registered cases include the overall number of persons admitted to narcological service providing facilities seeking treatment and later subjected to medical observation, and those, who underwent forensic-narcological and toxico-chemical expertise by the decisions of the law enforcing agencies, and therefore in registration on the ground of drug use and subject to medical observation.
However, narcological registration discloses only the visible part of the issues, since the majority of drug users are left out by institutions ensuring narcological and healthcare services.

Study on "Estimating the number of women providing sex services, men having sex with men, injecting drug users in the Republic of Armenia" conducted by "National Centre for AIDS Prevention" SNCO serves as another significant source for the assessment of the situation. However, through this study only the number of injecting drug users across the Republic was estimated excluding the number of drug users through other methods (smoking drugs, inhaling and drinking). According to the study findings, during the year of 2010 the estimated average number of injecting drug users constituted 12.700 (8.300-27.500) [1].

Drug users in our Republic, as in numerous countries of the world, often encounter legal, social and health-related issues that are triggered by not only the imperfection of state policy applied in relation to drug users, but also by stereotypical perceptions and discriminative treatment of state agencies and various strata of the society against this high-risk and utmost vulnerable group. Firstly, all this is certainly due to antisocial behavior often displayed by drug users. This is explained by the fact of acquiring morbid addiction to drugs.

As noted before, perceptions against drug users are highly controversial. The overwhelming majority of the society holds an opinion that drug addicts are not perceived as persons "suffering from a disease" (persons having diseases). Whereas, the behavioral disorders of a person due to drug use are classified by WHO as scientifically justified and quality approaches, pathological conditions and diseases requiring measures and processes

of consistent and effective prevention, medical assistance and care combined with psychosocial support, as well as rehabilitation and reintegration. [3,4,5]

International prestigious organizations dealing with illicit drug traffic and drug use, namely, World Health Organization (hereinafter WHO), and United Nations Office on Drugs and Crime regularly publish manuals and guidelines on effective implementation of health care policy in relation to drug users. Besides, they urge UN member states to be guided by the focal principles and standards set forth in the aforementioned publications, and adapt them to the local conditions upon necessity. Considering the inevitability of numerous social, legal and health-related issues emerging from the diseases caused by drug use, special attention is paid to the exclusion of drug users' breach of rights and stigma against them as recommended in the principles of international reputable organizations. The gaps existing in the policy implemented in relation to drug users in the Republic of Armenia and legal acts related to them are clearly visible even to the naked eye. Thus, the title of the legal act regulating the registration of drug users already contains a discriminative content, while the wording "narcoman" expresses a shade of meaning, which degrades human dignity. The aforementioned legal act defines that if drug substance (or drug metabolite) is detected in the biological environment of any person's organism, then the latter is subject to registration for a 5-year term and medical observation without specifying whether or not the person has a dependence syndrome. Similar discrepancies and ungrounded definitions are numerous in the above-mentioned legal act.

Another example touches upon the fundamental differences between "substantial", "large" and "extra large" quantities stipulated by the RA law on "Narcotic drugs and psychotropic substances", which envisions criminal liability, and the quantities defined in other countries' legislations. Consequently, there are also substantial dissimilarities in other countries regarding the penalties set for administrative and criminal offenses, as well as illicit turnover of drugs and drug use without a medical prescription.

"Small doses" set forth by the RA law on "Administrative offenses" are so small in quantity that it is virtually impossible that in separate cases a drug user's (especially a drug-addicted person, or a person having increased tolerance to narcotic drugs) even a single dose be so small. [6]

The aforementioned gaps instigate drug addicts to take actions due to morbid craving to drugs, which are almost constantly categorized as criminal offences, thereby, aggravating the life of drug-addicted persons, overcrowding detention facilities and contributing to the increase of funds spent on imprisonment.

GOAL OF THE STUDY

The goal of the study is to analyze the policy applied in relation to drug users in the Republic of Armenia, to assess the efficiency of the policy, to draw parallels with the principles put forth by international organizations and expertise of other countries, to evaluate the opportunities of introduction and application of international best practice in the Republic.

STUDY MATTER AND METHODOLOGY

The following RA domestic legal acts regulating the field have been observed and analyzed aiming to study the policy implemented in relation to drug users.

- RA law on Narcotic drugs and Psychotropic Substances
- RA Criminal Code
- RA Code on Administrative Offences
- Decision of the Government of Armenia "On setting the procedure of medical observation and registration of drug users" dated December 20, 2007
- N 532-A decree of the RA Minister of Health "On approving the Standards on Treatment of Narcological Diseases in the Republic of Armenia" issued on June 2, 2005
- N 1440-A decree of the RA Minister of Health "On approving Clinical Guideline of Opioid Substitution Treatment" dated December 12, 2006.

For comparison the guidelines, manuals and reports on the policy implemented in relation to drug users published by field-related international reputable organizations, including WHO, United Nations Office on Drugs and Crime, European Center of Monitoring on Drug and Drug Addiction, have been studied, along with strategic approaches and legal acts effective in CIS and EU counties, USA and other states.

SECTION 1. STIGMA AND DISCRIMINATION AGAINST DRUG USERS

The compliance of the use of terms applied in legal acts (including the terms "narcoman" and "narcomania") with the approaches adopted by field-related international organizations (including UN relevant departments).

1.1. Expression of stigma and discrimination against drug users and drug addicts

The focal reasons for the stigma and discrimination against drug users, as well as the opportunities of efficient measures undertaken for their exclusion have not been in-depth studied in Armenia prior to this.

According to the majority of the society, drug addicted persons are not "suffering from a disease" ("having a disease") in the first place.

The stigma and discrimination against drug users imply the stereotypical obstacles impeding the life quality of persons with diseases due to drug use.

More often alcohol addicted persons are also faced with similar issues, however, drug addicts, particularly, injecting drug users (opioid substances: heroin, desomorphine, opiate using persons) predominantly become a target for stigma and discrimination.

It is noteworthy that injecting drug users are a more vulnerable group at risk of HIV and viral hepatitis infection. Thus, HIV-infected drug users are virtually faced with "double" stigma since, as a rule, HIV-infected persons are also subjected to stigma and discrimination by the vast majority of the society. Due to stigma, discrimination and stereotypical attitudes directly related to them, the methods of combating drugs and drug abuse are degenerated into "fight against drug addicted persons". As a result, in this context it becomes "perceivable" and "acceptable" for the society that the best and easiest way of "fight drug addicted persons" is the application of punitive measures against them, such as, imprisonment, seclusion from the society, disintegration, as well as the overall indifference towards their health-related, legal and social issues.

The presence of stigma against drug users has also entailed certain stigma and marginalization against narcology and narcologists, in the first place. The role of narcologists is more often perceived by the society and sometimes also by narcologists themselves as a "specialist", whose main function is to "cleanse the society from "alcoholics" and "narcomans" and not as a key specialist providing medical assistance to persons suffering from grave diseases. Hence, with the created stereotypes the narcologists are vested with the society's special role of a "janitor", moreover, the

medical institutions providing narcological services are endowed with the role of a special lodge for “useless”, denied persons that are rightfully secluded from the society.

Significantly negative and ungrounded attitude of the society and the state agencies towards drugs and psychotropic substances used in practical medicine also adds to the stigma against narcologists. This causes all medical specialists (including psychiatrists and narcologists), who prescribe drugs and psychotropic substances to patients for treatment purposes as part of their daily work routine, to be in constant tension and hold negative attitude towards their professional activities.

During daily use of the terms“narcoman” or “sick with narcomania” applied in the legal acts effective in the Republic of Armenia, the fact of drug abuse by the person is brought into the forefront, which predominates over the person's other characteristic features (professional skills, educational background, character traits, marital status, temperament and others).

Public attitude towards drug addicts is formulated based on the following expressions regarding this vulnerable group which are quite common and do not at all comply with the reality, “narcomans are dangerous”, “grave will only cure narcomans” “narcotics are quitted in the grave”. Attitude triggered by such stereotypical mentality does not tend to be changes even if a drug addicted person attempts to do his/her best (get treated, self-attempts to quit drugs) possible to abstain from drug use.

The majority of mass media publications regarding drug users are presented as criminal offences committed by the latter usually failing to address and pay attention to a more focal issue of health aspect. Such an approach contributes to the formation of the attitude against drug addicted persons as socially ill, “dangerous elements of crime” “useless” person, and “good for nothing”, which itself leads to disproportionate and ungrounded conviction and desire not to support persons actually suffering from a severe chronic disease, but instead to definitely isolate them from the society.

1.2. Consequences of stigma and discrimination against drug users

Similar attitude towards drug addicted persons causes them to conceal their issues; they not only avoid society, relatives, colleagues and surrounding people, but also refrain from applying to healthcare institutions. As a result, persons suffering from mental and behavioral disorders gradually become secluded, thereby aggravating the course of their illness and decreasing the chances of efficient treatment, rehabilitation and reintegration.

Besides, such a stereotypical mentality and attitude against drug addicted persons, and categorizing these persons, who truly suffer from a severe chronic disease, along with under groups that were marginalized from society due to reasons other than illness (the homeless, prostitutes) leads to the public conviction that drug use and later also drug addiction is not a threat that could happen to them or their children, which consequently abates the vigilance of both society and individuals, including parents and caregivers.

Thus, it can be stated that stigma and discrimination against drug addicts, identification of drug use with crime, punitive attitude towards drug users, their marginalization and seclusion from the society in no way favors to the increase of effectiveness for combating illicit turnover of drugs. Conversely, they pose even greater obstacles to the treatment of drug addiction, and prevention of drug use among the population.

1.3. Terms used in international legal documents, official publications of international organizations, and domestic legal acts of the Republic of Armenia

As stated before, stigma expressing terms are contained in the terms put forth firstly in the RA domestic legal acts regulating the policy implemented in relation to drug users such as "narcoman" [1] and "narcomania" [2] terms.

Nonetheless, the direct foreign translations for these terms have not been for long used by WHO, and other international reputable organizations dealing with drugs.

Currently, nomenclature dependence set forth in the Diagnostic and Statistical Manual Fourth Edition[3] and recommended by the American Psychiatric Association, as well as criteria applied in the International Classification of Diseases, Tenth Revision (hereinafter ICD-10) proposed by the WHO, are widely acceptable across the world: in both cases diagnostic criterion "psychotropic substance dependence" and not "narcomania" is defined [3,7].

The main international legal documents on the control of narcotic drugs and psychotropic substances are the UN Conventions on Narcotic Drugs and Psychotropic Substances, which was also joined by the Republic of Armenia in 1993. Since 1993 the Republic of Armenia has joined the following UN Conventions on drug traffic.

- Single Convention on Narcotic Drugs, 1961
- Convention on Psychotropic Substances, 1971
- Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

"Drug addict" [4] term is used in the section about treatment of drug addicts of the original english document on Single Convention on Narcotic Drugs (page 5), dated 1961.

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[1] http://www.arlis.am/DocumentView.aspx?DocID=41779

[2] http://www.arlis.am/DocumentView.aspx?DocID=85736

[3] Diagnostic and Statistical Manual of mental disorders (DSM IV)

[4] https://www.incb.org/documents/Narcotic-Drugs/1961-Convention/convention_1961_en.pdf

"Drug addict" term is literally translated as "drug dependent" («թմրամիջոցից կախվածություն»). In the Russian version of the Convention "narcoman"[5] term was used (page 6)[6], while the corresponding part in the Armenian translation is completely omitted.[7]

"Abuse of drugs" nomenclature was applied in another provision enshrined in Single Convention on Narcotic Drugs, 1961 (Article 38) of the original English document, which was directly and proportionately translated in the Armenian version "drug abuse" («թմրամիջոցների չարաշահում»).

The terms "narcomania" and /or "narcoman" as well as "alcoholism" and/or "alcoholic", "alcohol addicted" set forth in ICD-10 published by WHO, and officially effective in the UN member states (including the Republic of Armenia) are not applied to describe (diagnose) the health state or disorder of drug and alcohol users and persons addicted to them.

Use of psychotropic (psychoactive) substances (including narcotic drugs), clinical conditions, and disorders are classified in ICD-10 under F10 to F19 codes, summarized under "Mental and behavioural disorders due to psychoactive substance use" clause. The disorders and clinical conditions due to the use of psychotropic (psychoactive) substances of each block (category) are classified separately. For instance, the disorder (or clinical condition) induced by dependence on opioids is diagnosed as follows, "Mental and behavioural disorders due to use of opioids. Dependence syndrome"(Code F11.2). Or, for example, in case of harmful use of opioids (when the person doesn't experience symptoms typical of the dependence syndrome, but the use of opioids has already inflicted damage to mental and/or physical (somatic) health), the following diagnosis is made: "Mental and behavioural disorders due to use of opioids. Harmful use"(Code F11.1). The same principle applies to the disorders and clinical conditions due to the use of psychotropic substances and narcotic drugs of other blocks (categories) [3,8].

According to our study findings, terms "narcomania" or "narcoman" have not been used in the official reports, guidelines and manuals released by all international reputable organizations (including WHO, United Nations Office on Drugs and Crime[8], International

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[5] Russian "наркоман" (it is literally translated as "drug addict") term is comprised of the word roots «ναρκωτικός» in Greek (Latin: narcosis) (Armenian: stupor, narcosis) and μᾰνία (Latin: mania) (Armenian: morbid addiction, madness).

[6] https://www.incb.org/documents/Narcotic-Drugs/1961-Convention/convention_1961_ru.pdf

[7] http://www.arlis.am/DocumentView.aspx?DocID=80566

[8] United Nations Office on Drugs and Crime (UNODC)

Narcotics Control Board[9], European Monitoring Centre for Drugs and Drug Addiction[10]) dealing with drug turnover, illicit traffic of narcotic drugs, and drug users within the last 10 years in spite of the crucial fact that "narcotic", "narcomania" terms (Armenian direct translation for "narcomania" is «թմրամոլությունն» and Armenian direct translation for «narcoman» is «թմրամոլ») that originate from Greek, are internationally recognized definitions widely used across the world since BC.

The terms "drug dependence", "drug addiction", "drug use", "drug abuse" are applied in international legal acts and publication of international reputable organizations.

International organizations, namely, WHO and United Nations Office on Drugs and Crime, regularly publish manuals and guides on effective implementation of healthcare policy in relation to drug users.

Besides, they urge UN member states to be guided by the focal principles and standards set forth in the aforementioned publications and upon necessity adapt them to the local conditions. Considering the inevitability of numerous social, legal and health-related issues emerging from the disorders caused by drug use, special attention is paid to the exclusion of drug users' breach of rights and stigma against them in the principles recommended by international reputable organizations [9,10].

The term "narcoman" ("narcomans") contained in the headline and also in the text of RA decision "On setting the procedure of medical observation and registration of drug users" is disproportionate, devoid of any scientific justification, and outdated, moreover, it does not comply with the approaches of international prestigious organizations on the examination, treatment, registration and medical observation of drug users and drug addicts, meantime creating basis for the discrimination and stigma against drug users at national level [2].

It is also noteworthy that the term "narcomans" cannot serve a generic term for all drug users from both medical and legal perspectives. Even if we don't consider the presence of stigma in "narcoman" term and the fact of excluding its application by international organizations, a number of other issues emerge. Namely, according to the aforementioned decree, if toxico-chemical expertise detects drugs or drug metabolite in the biological environment of a person's organism, then the latter is registered as a "narcoman". It is quite likely that after first-time use of drugs any person can be registered as a "narcoman" … A question emerges: what is the sense of "narcomania", "expressed morbid craving" or "mania" in a person, who has tried drug use for the first or second time, if medical-scientific research excludes the possibility of "dependancy" or "morbid carving" after one or several exposures to the majority of narcotic drugs and psychotropic substances. [2, 11, 12, 13, 14]

[9] International Narcotics Control Board (INCB)

[10] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Sub-paragraph 1 of Paragraph 10 of the decree provides, "… a citizen's first visit to narcologist, as result of which "narcomania" diagnosis is given." However, "narcomania" diagnosis simply doesn't exist in ICD-10 effective in the Republic of Armenia from 2005. [3]

"Narcomania" and "patient with narcomania" terms are also applied in the RA law on Narcotic Drugs and Psychotropic (psychoactive) Substances, where the explanation of the terms is given: "narcomania" is a disorder triggered by the use of narcotic drugs and/or psychotropic (psychoactive) substances in line with the classification of diseases effective in the Republic of Armenia, while, a "patient with narcomania" is a person diagnosed with "narcomania" through medical examination pursuant to the order defined by law. It is worth adding to the aforementioned (the fact that term "narcomania" as clinical description of a disease is ungrounded") that defining diseases due to the use of psychotropic (psychoactive) substances as "narcomania" is also unjustified, just because psychotropic substances (including the majority of sedative hypnotics, tranquillizers, volatile solvents, hallucinogens) are not classified via international and Armenian domestic legal acts as drug substances.[11] [3, 15, 16]

[11] http://www.arlis.am/documentview.aspx?docid=74165

1.4. Recommendations

1. To replace “narcomania” word in the RA law on drugs and psychotropic (psychoactive) substances with “disorder (disorders) due to use of drugs and psychotropic substances” clause specified by the ICD-10 effective in the Republic of Armenia.
2. To replace “patient with narcomania” expression in the RA law on drugs and psychotropic (psychoactive) substances with “a person with disorder (disorders) due to use of drugs and psychotropic substances” clause.
3. To replace term “narcoman” (“narcomans”) contained in the headline and text of the RA decision “On setting the procedure of medical observation and registration of drug users” with “a person with disorder (disorders) due to use of drugs and psychotropic substances” clause.
4. We urge mass media outlets to refrain from the application of words and terms that create extremely negative stereotypes, stigma and discrimination against drug users in publications and disseminations about them, such as the terms “narcoman” and “narcomania”. At the same time, contribute to the formulation of public mindset and attitude towards healthy lifestyle free from dependence inducing substances like drugs, alcohol and tobacco.
5. Training of specialists and employees of competent state agencies, medical institutions and NGOs dealing with drug users. To formulate and demand respect towards drug users' human dignity particularly by excluding terms and texts containing stigma, discrimination and negative attitude.
6. To exclude the application of terms “narcoman” and “narcomania” in the publications (reports, records, guidelines, manuals, articles, monographs) released by state agencies, NGOs and research conducting individuals.
7. To ensure professional Armenian translations of field-related international documents joined by the RoA that must comply with the text of original document.
8. To regularly estimate the prevalence in drug use across the Republic based on the methodology and principles recommended by United Nations Office on Drugs and Crime, European Center of Monitoring on Drug and Drug Addiction.

SECTION 2. PENALTIES FOR DRUG USE AND ILLICIT DRUG TRAFFIC

The objectivity assessment of "small quantities" of narcotic drugs representing various categories (groups) enshrined in the Code of the Republic of Armenia on administrative offenses, the level of their justification (also taking into account the daily portion intakes by drug addicted persons in the Republic of Armenia), as well as the parallels of "quantities" defined by the RA legal acts with the experience of other states. The opportunities for integration and application of international best practice in the Republic of Armenia

The objectivity assessment of "considerably large" narcotic drugs established by the Criminal Code of the Republic of Armenia, the level of their justification, the fairness and efficiency of criminal liability (including cost-effectiveness) foreseen for the illicit turnover of narcotic drugs in the mentioned quantity as well as comparison with international expertise. The opportunities for integration and application of international best practice in the Republic of Armenia

2.1. Observations on legal acts defining penalties for drug use and illicit drug traffic

The RA Criminal Code adopted by the RA NA on April 18, 2003, sets liability for the criminal offence in connection with illicit turnover of narcotic drugs, psychotropic substances and their precursors.

The former edition of the RA Criminal Code also set liability for the use of narcotic drugs without medical prescription. However, as a result of legislative amendments dated May 26, 2008, Article 271 of the RA Criminal Code setting liability for the aforementioned action was recognized invalid. Instead, administrative liability for the use of narcotic drugs or psychotropic substances without medical prescription was defined in Article 44^2 of the RA Code on Administrative Offences.

Similarly, the illegal turnover of narcotic drugs or psychotropic substances in small quantities without a purpose of sale has been decriminalized, and an administrative sanction for it has been established.

With another legislative amendment, small quantities of narcotic drugs or psychotropic substances have been enshrined in the RA Code on Administrative Offences, while considerable, large and especially large amounts are established by Annex to this Code.

Since the Republic of Armenia has joined the international conventions related to narcotic drugs and psychotropic substances, it is noteworthy that the focal strategic approaches and principles of the Republic of Armenia and UN member states regarding fight against illicit traffic of narcotic drugs coincide. In the meantime, it is worth noting that differences of approaches exist in the domestic legal acts regarding defined control over the use and illicit traffic of narcotic drugs and psychotropic substances. Particularly, there are substantial differences between "considerable", "large" and "especially large" quantities set forth in the legislations of other states and those defined in the RA law on narcotic drugs and psychotropic (psychoactive) substances, adopted by the RA NA on April 18, 2003 and foreseeing criminal liability. Therefore, there is also major variance between administrative sanctions established for illicit drug traffic and drug use without medical prescription and penalties for criminal offences.

Aricle 44^1 of the RA Code on Administrative Offences provides,

> *1. Illegal manufacture, processing, procurement, keeping, trafficking or supplying of small quantities of narcotic drugs or psychotropic substances without the purpose of sale establishes administrative fine in the amount of 200 to 400 times of the minimum wages*[12] .
>
> *2. For the second time of its detection throughout 1-year period an administrative fine in the amount of 400 to 800 times of the minimum wages is determined.*

[12] According to the Article 3 of the RoA the Law "On Minimum Monthly Wages", the bases for calculating minimum monthly wages within the RA Codes, laws and substitute acts is 1000 Armenian dram

3. Define in this Chapter the small quantities of narcotic drugs and psychotropic substances in line with the Annex to this Code.

4. The person surrendering possessed small amount of drugs or psychotropic substances on his/her own initiative is exempted from administrative liability for the offence envisioned in this article.

Aricle 44^2 of the RA Code on Administrative Offences provides,

1. Use of narcotic drugs and psychotropic substances without a doctor's prescription implies administrative fine in the amount of 100 to 200 times of the minimum wages.

2. The second time of committing the same act throughout 1-year, an administrative fine in the amount of 200 to 400 times of the minimum wages is determined.

3. The person, who turned to a relevant medical institution for assistance in relation to use of narcotic drugs and psychotropic substances without a doctor's prescription, on his/her own initiative, is exempted from administrative liability for the offence envisioned by this article.

The definitions regarding the quantities of several more common drugs should be viewed in order to evaluate the justification of "considerable", "large" and "especially large" amounts, stipulated in the RA Criminal Code, and "small" amounts defined by the RA Code on Administrative Offences.

According to the official data (narcological registration), the use of opioids (Heroin, Acetylated opium, Opium, Morphine, Buprenorphine, Desomorphine, Codeine) and Cannabis drugs (Marijuana, Hashish) is predominantly common in the Republic of Armenia.

2.1.1. Opioids

Let's view the justification of "small" quantities stipulated by the RA Code on Administrative Offences in the example of "small" amounts defined for the class of opioids, a class posing more hazardous consequences to individual and public health.

The group (class) of opioid substances or opiates includes sedative alkaloids derived from papaver somniferum (opium poppy), their semi-synthetic derivatives, artificially synthesized analogues, as well as compounds synthesized in the organism, which act as agonists of opioid receptors for the organism producing analgesic and euphoric effects.

Opioids are widely used in medicine to for analgesic purposes (Morphine, Codeine, Papaveretum[13], Fentanyl, Heroin in a number of countries) and substitution treatment (methadone, buprenorphine[14]). At the same time, due to expressed euphoric effects of opioids, the drugs of this class are widely used by drug users, too. According to the official statistics, the illicit use of opioids in Armenia is the second with its prevalence coming after cannabinoids.[1]

Pursuant to the RA Code on Administrative Offences, 0,005 gram was determined for the "small" quantity of Heroin, regardless of the content of active substances, 0,02 gram for Acetylated opium with content of active substances, 0,05 gram for Desomorphine, 0,1 gram for Opium, 0,02 gram for Codeine, 0,01 gram for Morphine, 0,002 gram for Buprenorphine, while **0,1 gram (100 milligram) for Methadone.**

Addressing the objectivity and justification of "small" quantities provided by the RA Legislation, it should be pointed out, the "small" quantities established for opioid substances are so small that are often insufficient for a single dose of regular and long-term drug users of opioids. The quantity defined for each of the opioid substances (except for the "small" amount set for Methadone) consumed by drug users is so small that opioid users are virtually obliged to constantly serve their penalties for criminal rather than administrative offence, because the necessary "required" amount for a single dose of opioids in order to overcome the withdrawal syndrome by a person with high tolerance[15] to opioids, triggered by addiction, should not exceed the "small" quantities established by law.

In terms of similar effects from the viewpoint of their expressiveness, duration and potential of creating dependence, it is almost impossible to accurately calculate the equivalent doses of various types of opioids in practice, taking into account their "level of purity", the fact that the active substance (net drug) of drugs obtained through

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13 Papaveretum (Omnopon) is a mixture of alkaloids produced from Papaver somniferum with contents of morphine, Codeinee, papaverine, narcotine and thebaine.

14 Chemical formula is C29H41NO4. Other names include, Subutex, Norphin, Buprenal and etc. It is semi-synthetic opioid and is practically used in medicine as analgesic. In a number of countries (France, Germany, Ukraine and etc) it is also used as substitution treatment for persons with opioid addiction. Illicit use of Buprenorphine via injection is wide-spread in numerous countries, including also Armenia.

15 Term "Tolerance" in Pharmacology and Narcology refers to a decrease in organism reaction (responsiveness) to narcotic drugs, psychotropic and other substances after their repeated use, as a result, it becomes necessary to gradually add the doses of taken substance to yield the previous effect.

"street" and "homemade" sources is highly variable, it is used and circulated as a compound to other substances. However, we can draw accurate inferences through comparison of equivalent dosages of various opioids applied in medicine. Obviously, in this case there is no need to consider the specifics emerging from the effect duration, metabolism and usage methods of various opioid substances, since our target is not the clinical effects of opioids, but rather the legal definitions on their quantities.

Taking Methadone as grounds for comparison, let us view the equivalent dosage of opioids.

The dosage of a number of opioids and their equivalent in Methadone is presented in the table below [17]:

Equivalent oral dosage	**Drug use method**	**pharmaceutical form and dosage**	**Methadone dosage**
Diacetylmorphine(heroin)	Intravenous	10 mg, vial 30 mg, vial	20 mg 50 mg
	peroral	10 mg	20 mg
Methadone	Intravenous	10 mg, vial	10 mg
Morphine	Intravenous	10 mg, vial	10 mg
	peroral	10 mg	10 mg
	rectal	10 mg	10 mg
Dipipanone	peroral	10 mg	4 mg
DihydroCodeine	peroral	30 mg	3 mg
Dextromoramide (Palphium)	peroral	5 mg	5-10 mg

		10 mg	10-20 mg
Pethidine	Intravenous	50 mg, vial	5 mg
	peroral	50 mg	5 mg
Buprenorphine	Intravenous	300 mcg, vial	8 mg
	peroral	200 mcg, tablet	5 mg
Pentazocine	peroral	25 mg, tablet 50 mg, capsule	2 mg 4 mg
Codeine syrup 100 ml	peroral	300 mg (Codeine phosphate)	10 mg
Codeine phosphate	peroral	15 mg, tablets 30 mg,tablets 60 mg, tablets	1 mg 2 mg 3 mg
Syrup G 100 ml	peroral	16 mg morphine	10 mg
J. Cole Brown 100 ml	peroral	10 mg extracted opium	10 mg

The comparisons presented in the table relate to medical "pure" doses of opioids (without any compounds).

According to the RA Code on Administrative Offences, the "small" quantity for Methadone is up to 0,1 gram (100 mg), and up to 0,005 gram (5 mg) for Heroin. Although with its effect 20 mg dose of Methadone equals to 10 mg of **Heroin**.

Addressing **Morphine**, it should be specifically stressed that the dosage for a single use of Morphine in medicine constitutes 10-20 mg, while the possible maximum daily dose prescribed by a doctor is 50-200 mg. Whereas, the "small" quantity of Morphine, determined by the RA Legislation, is up to 10 mg, which is not sufficient even for the single dose of an opioid addicted person. This fact is contingent upon the increase of tolerance to opioids triggered by the disease.

The RA Legislation sets the "small" quantity for **Codeine** up to 0,02 gram (20 mg), which is the weakest in effect among other opioid substances. It should be pointed out that the Methadone equivalent of 20 mg Codeine is 1 mg less. Whereas, the "small" quantity stipulated by the RA Code on Administrative Offences is up to 100 mg for

Methadone and 20 mg for Codeine. The fact that a number of multi-compound analgesics, where Codeine quantity is about 10 mg, are freely sold in the Republic's drugstores, also speaks of the weak effect of Codeine and less harm as compared to other opioid substances.The emerging illogical hypothesis that in three tablets of multi-compound pain killer containing 8 mg Codeine (24 mg Codeine) already constitutes a "considerable" quantity, and serves as basis for applying criminal penalty against a person.

According to the RA Legislation, over 0,02 gram (20 mg) is set for the "small" amount of **Omnopon**, it is noteworthy that Omnopon is a solution of alkaloids comprised of Morphine, Codeine, Papaverine, Narcotine and Thebaine. 1ml of the Omnopon solution contains 5,75-13,4 mg Morphine and 0,72-1,44 mg Codeine, respectively. Prescribed single dose of Omnopon constitutes 1-2 milliliter (1-2 gram solution). This quantity is also quite small for even one-time dose for persons with Omnopon addiction, and increased tolerance to it.

The RA Code on Administrative Offences establishes 0,002 gram (2 mg) as the "small" amount for **Buprenorphine** (subutex). According to the literature on the use of Buprenorphine for medical purposes, the single dose prescribed for **analgesic effect** constitutes 0,2-0,4 mg, while its maximum allowed dose per day is about 1,8 mg[16]. However, it is noteworthy that daily treatment (conservative) doses of Buprenorphine used in **opioid substitution treatment** totaling 16 mg are significantly greater than those used for analgesic purposes. It can be inferred from here that 2 mg of Buprenorphine serves as the minimum or even insufficient single dose for persons with opioid addiction. As compared with Methadone, it should be stressed that the equivalent for 100 ml dose of Methadone is 4 ml of Buprenorphine, which is twice greater than the "small" amount set by the RA Legislation. [5]

Since **Methadone** doses were taken as basis for the estimation of the quantities defined for opioid substances, it is also necessary to address the doses of Methadone prescribed for opioid addicted persons.Thus, a daily Methadone dose of over 25-30 mg is prescribed for opioid addicted persons in the initial stage of Methadone substitution treatment. However, as a general rule, the daily doses of Methadone are gradually increased and already 2-3 weeks later, in the phase of maintenance treatment, the prescribed daily dose of Methadone constitutes 60-120 mg. In separate cases, if a person has high tolerance to opioids, triggered by opioid addiction, the amount of treatment Methadone dosage can exceed 120 mg.

[16] Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, WHO, 2009

Based on the aforementioned comparisons and analyses regarding the quantities of various substances under the group of opioids, we can infer that the "small" quantities of drugs, punishable by administrative sanctions set in the RA Code on Administrative Offences, and "considerable" amounts envisioning criminal sanction by the RA Criminal Code do not comply with the level of pathological adherence of drug addicted persons, and they don't virtually contribute to the "evasion" of criminal penalty and turning for medical assistance by drug addicted persons. Conversely, the vast majority of drug addicted persons, who have developed increased tolerance to drugs as a result of long-term exposure and are "obliged" to use greater doses in order to relieve the withdrawal symptoms, in most of the cases procure and keep "considerable" amounts set by the RA Criminal Code instead of "small" quantities of drugs defined by the RA Code on Administrative Offences. As a result, the drug addicted persons are subjected to criminal and not administrative sanctions for possessing drugs for personal use.

It can be stated that **only** those drug users, who at the time of their detection by law enforcement officers do not happen to have even a single dose of drugs, are in practice subjected to administrative sanctions. In this case, the conclusions of toxico-chemical lab expertise, appointed by the decree of law enforcement bodies, and the positive findings of drug metabolites in the specimens taken from a person's biological environment (urine, hair, nail, blood samples) identified by the expertise, as well as detection of the fact of drug use based on the conclusions above serve as grounds for the determination of the administrative penalty.

It should be also highlighted that according to the Annex of the RA Code on Criminal Offences regarding "small" quantities, during the calculation of seized drugs amount, the presence of compounding substances, other non-drug compounds of the mixture, is disregarded. Whereas, the "street-sold" and "home-made" drugs are mainly mixtures containing various substances, where, in the total mass, the "pure" quantity of the drug is extremely variable and often quite small.

Article 268 of the RA Criminal Code (Illegal turnover of narcotic drugs or psychotropic (psychoactive) substances without the purpose of sale) provides,

> *1. Illegal manufacture, processing, procurement, keeping, delivery or supply of narcotic drugs or psychotropic (psychoactive) substances without the purpose of sale* ***in considerable amounts****, is punished with arrest for a term of up to 2 months or with imprisonment for a term of up to 1 year.*

It follows from Article 268 of the RA Criminal Code that the procurement, keeping, delivery or supply of a single dose of narcotic drugs serves as grounds for a person's imprisonment.

In this case it can be stated that instead of getting professional medical assistance, a person is subjected to imprisonment for a term of 2 months or 1 year for keeping a tiny dose of drug due to existing disease.

As a result of such a policy the imprisonment of a drug addicted person and failure to provide medical assistance cannot be justified both in terms of human rights and cost effectiveness. Thus, the daily cost for an imprisoned person constitutes 4500 AMD, while, the average daily expense for a person undergoing Methadone Substitution Treatment in outpatient (ambulatory) care is 300-400 AMD, and 6000 AMD[17] daily for a maximum of 24 days of in-patient detoxification treatment.

Besides, special attention should be paid to fact that the likelihood of abstinence from drugs due to professional medical support and exclusion of criminal conduct is far greater than in case of imprisonment.

Here it should be pointed out that we consider the cases when a drug addicted person has procured, kept or transported "the specific" dose of drug for personal use without the purpose of sale.

[17] National report on drugs, WHO, 2014

2.2. International approaches on defining drug quantities and keeping "small" amounts of drugs

Various countries have adopted quite diverse approaches regarding both the "quantities" of drugs and keeping of drugs. However, it is noteworthy that the domestic legislations in none of the target countries of this study have defined the "small" quantities of drugs as small as the legislation of the Republic of Armenia.

The quantities of drugs in Australia are defined under 5 ranges: "small quantity", "trafficable quantity", "indictable quantity", "commercial quantity", "large commercial quantity". Namely, the "small quantity" set for Marijuana is 30 gram, 5 gram for Hashish, 1 gram for Cocaine and 1 gram for Heroin. The penalties for drug possession in Australia are quite stringent. Particularly, an administrative fine in the amount of 5.500 dollars or imprisonment to a maximum of 2 years is defined for the possession of "small quantities" of drugs.

In the Russian Federation the "small" quantity determined for Heroin and Methadone is 0,5 gram, 0,1 gram for Morphine, 1 gram for Codeine, 0,5 gram for Cocaine and 0,005 gram for Buprenorphine. The administrative sanctions envisioned for the "small" quantities of drugs effective in the Russian Federation do not greatly differ from those set by the RoA regulations. In the Russian Federation an administrative fine in the amount of 4.000-5.000 rubles is determined for drug use for Russian citizens.

Both in the Russian Federation and in many other CIS member states, including Belarus, Kazakhstan and Kyrgyzstan, "small quantity" of drugs, widely spread in our region, and stipulated by the legislations of the above countries, exceed the threshold of "small" quantity defined by the RA law.

The approaches in the EU counties are quite diverse, nonetheless, the set "small" amounts of drugs or the quantities of drugs, which don't entail criminal liability are significantly greater as compared to the "small" quantities defined by the RA law.

Thus, in Austria, Denmark, Belgium, Germany, Czech Republic, Netherlands, Italy, Slovakia a person is not subjected to a penalty for drug use, it means, drug use is not deemed a criminal or administrative offence. [18]

In countries like France, Croatia, Hungary, Romania, Greece, Cyprus, Great Britain, Estonia, Sweden, Norway various penalties are envisioned for drug use: from

[18] http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance

fines of various amounts to short-term imprisonment, mainly with opportunities of alternative penalties.

Possession of narcotic drugs for personal use is defined as an offence in many of the EU member states; however, various approaches are foreseen.

In Germany unauthorized possession of drugs carries a penalty of up to 5 years' imprisonment. However, the law refrains from prosecution if only "small" quantities of narcotic drugs for personal use are involved.

In Belgium the possession of "small" amounts of Marijuana for personal use carries a fine, whereas, keeping of "small amounts" of harder drugs is punished with 3-5 months' imprisonment.

In Italy the possession of "small amounts" of drugs for personal use does not carry a penalty.

In the Czech Republic the possession of "small amounts" of drugs for personal use carries a penalty, while keeping of drugs greater than "small amounts" attracts a criminal penalty, namely imprisonment, and its term varies determined by the drug type.

The possession of "small amounts" of drugs for personal use also attracts a sentence of up to 2 years in Denmark. However, upon finding of drug addiction evidence, the person is exempted from criminal liability.

Generally speaking, administrative and criminal penalties are envisioned for offences related to illicit drug traffic in all of the EU states, however, in the meanwhile almost in all of the EU countries a range of alternative punishments apply: in the presence of drug addiction, medical assistance is determined as an alternative or a rational approach to imprisonment, appointment of substitution or rehabilitation treatment by the court's decree and other flexible, humanitarian and meantime cost effective approaches are available.

"Small amounts" defined for different types of drugs vary across EU countries. Thus, 1,5 gram Heroin, 1 gram Cocaine, 5 gram Cannabis are envisaged in the legislation of Czech Republic as "small amounts". 1 gram Heroin and Cocaine, 6 gram of Cannabis is set as small amount in German Federation. 3 gram Heroin, 7,5 gram Cocaine and 100 gram of Cannabis in Spain; 0,25 gram Heroin, 0,75 gram Cocaine and 1 gram of Tetrahydrocannabinol in Italy; 0,02 gram Heroin, 0,2 gram Cocaine, and 5 gram of Cannabis in Lithuania; 0,6 gram Heroin, 2 gram Cocaine and 1 gram of Tetrahydrocannabinol in Hungary; 3 gram Heroin, 15 gram Cocaine and 20 gram of Tetrahydrocannabinol in Austria; 1 gram Heroine, 2 gram for Cocaine, and 5 gram of Tetrahydrocannabinol in Portugal; 0,5 gram Heroin, 0,5 gram Cocaine, 10 gram

Cannabis in Norway are set as “small amounts” for possession of drugs for personal use. [19]

It should be once again emphasized that the objective evaluation of disease induced “obliged” drug use by drug users underlies such a policy of the states along with further implementation of rational and cost effective measures through provision of effective and quality medical assistance and services to drug addicted persons instead of possessing, procuring “small” amounts of drugs for personal use and sentencing them to imprisonment.

[19] http://www.emcdda.europa.eu/html.cfm/index99321EN.html

2.3. Recommendations

1. Review and revise the “small amounts” of drugs representing various classes (groups) stipulated by the RA Code on Administrative Offences on the basis of disease induced morbid urge to drugs by drug users and drug addicted persons, as well as international best practice.
2. Review and revise the “considerable amounts” of drugs representing various classes (groups) stipulated by the RA Criminal Code as well as “large” and “especially large” quantities based on the principle of fairness of the RA Criminal Code, disease induced morbid craving for drugs by drug users and drug addicted persons, as well as international best practice.
3. To apply more rational and effective approaches (alternative penalty or appointment of effective and quality enforced treatment) towards persons in case of illicit traffic of drugs.

SECTION 3. REGISTRATION OF DRUG USERS AND MEDICAL OBSERVATION

The "classification" of drug users according to international approaches and classification of diseases.

The legal and professional (healthcare: narcological) justification of the order effective in the RA (decree of the RA Government on registration of drug users and medical observation) on the medical observation applied in relation to drug users (including those without addiction syndrome) and drug addicted persons, parallels with international standards and approaches effective in other countries, as well as the efficiency assessment of registration and medical observation implemented in the Republic of Armenia. The opportunities of integration and application of international best practice in the RA

3.1. Study of legal acts effective in the Republic of Armenia, which regulate the process of registration based on drug use

Pursuant to Article 48 of the RA law on Narcotic Drugs and Psychotropic (psychoactive) Substances:

1. *"The individual, who without the medical prescription, rarely or regulatory in short term uses narcotic drugs and psychotropic substances and who by the medical examination at an outpatient or inpatient clinic is devoid of any imminent danger of the physiological or psychological stable dependency, shall be subject to a* ***short-term*** *medical observation.*
2. *An individual who has voluntarily received a mandatory or obligatory treatment course has recovered partly or fully, shall be subject to* ***long-term*** *medical observation."*

N 1599 decree of the Government of the Armenia "On setting the procedure of medical observation and registration of drug users" dated December 20, 2007 fails to specify in any way the cases of "short-term" and "long-term" medical observation of citizens. It is not either clarified whether 5-year long medical observation is a "long-term" or "short-term observation".

Moreover, pursuant to the decision "On setting the procedure of medical observation and registration of drug users", all those citizens, who have undergone a toxico-chemical lab expertise, and if product of drug metabolism is detected in the biological environment of their organism, are subject to registration for a 5-year term and medical observation.

Hence, although according to the RA law on Narcotic Drugs and Psychotropic (psychoactive) Substances, The individuals, who **rarely or regulatory in short term** use narcotic drugs and psychotropic substances, are subject to short-term medical observation, however, pursuant to the decision "On setting the procedure of medical observation and registration of drug users", there is no distinction between mechanisms regulating drug users' registration, their elimination from registration as well as the duration of medical observation of **"rarely or regulatory in short term"** drug users, and those who **"voluntarily received a mandatory or obligatory treatment course, have recovered partly or fully".**

Taking into account the aforementioned incompliance of the RA law on Narcotic Drugs and Psychotropic (psychoactive) Substances and decision of the RA Government "On setting the procedure of medical observation and registration of drug users", it should be specifically emphasized that there are serious controversies between these two acts regulating the policy implemented in relation to drug users in the Republic.

Subparagraphs 4, 6 of Paragraph 10 of the same decision are worth considering separately,

According to Subparagraph 4 of Paragraph 10 of decision of the RA Government "On setting the procedure of medical observation and registration of drug users, **cases of drug users' registration** are,

> *4) "All the copies of toxico-chemical lab expertise (regradless of subordination) sent to the medical clinic rendering outpatient narcological services in the citizens' place of registration."*

However, it should be pointed out that **only** through toxico-chemical expertise, it is impossible to determine,

- The frequency of drug use by an individual.
- Whether the individual has "psychological or physiological" addiction (as stipulated in the RA law on Narcotic Drugs and Psychotropic (psychoactive) Substances) to drugs.
- Whether or not the individual needs treatment.

Through toxico-chemical expertise it is possible to answer **only** one question, whether drugs are or were found in a person's organism, whether the person has used drugs recently (the retention period of drugs and metabolites in the organism is

contingent upon the type of used drugs and also a person's physiological peculiarities to some extent). According to Subparagraph 6 of Paragraph 10 of decision of the RA Government "On setting the procedure of medical observation and registration of drug users", the following is also deemed as **registration of drug users,**

> *6) Copies of checks of Ambulance calls related to the use of drugs and* ***psychotropic substances*** *sent to the medical clinic rendering outpatient narcological services in a person's place of registration.*

In case of the condition set forth in Subparagraph 6 of Paragraph 10 of decision of the RA Government "On setting the procedure of medical observation and registration of drug users", the conclusion of the doctor rendering medical assistance and care as a result of Ambulance call regarding the use of drugs, and **psychotropic substances**, serves a ground to register a person as a **"narcoman"**. However, it should be noted,

- The substances defined by the term "psychotropic substances" applied under Subparagraph 6 of Paragraph 10 are not under the category of drugs, and consequently, considering a person, who uses psychotropic substances for any time period a **"narcoman",** is not justified.
- Calling for Ambulance due to use of drugs by the citizens can be contingent upon not only long-term use of drugs, or addiction to them, but also cases of acute intoxication ("overdosing") triggered by single use of drugs. In line with the logic put forth in Subparagraph 6 of Paragraph 10 of the aforementioned decree, a person without alcohol addiction can be registered as "alcoholic" as a result of Ambulance call regarding the case of intoxication triggered by the abuse of alcoholic drinks.

It is noteworthy that due to this specific reason a number of people, who are episodic drug users, do not possess "psychological or physiological addiction" are being registered and subjected to 5 years' medical observation.

Pursuant to Paragraph 16 of the decree of the Government of Armenian "On setting the procedure of medical observation and registration of drug users",

> *16. The personal contact of the territorial doctor-narcologist and co-working territorial nurse or feldsher with the drug user under registration is only considered medical observation.*

It is worth addressing that the decision **"On setting the procedure of medical observation and registration of drug users"** fails to specify whether "the personal contact with the drug user" expression, which clarifys the term "**medical observation**"

as stipulated in Paragraph 16, is an inquiry, examination, toxico-chemical expertise or another action.

Paragraph 16 virtually provides that medical observation can also be conducted by the territorial **nurse or feldsher** co-working with the territorial doctor-narcologist. A question emerges here: how can such a function be carried out by employees (nurse or feldsher) with secondary medical education background, if the conclusion on the person's relapse to drug use (interruption of remission) and setting of diagnosis require a level of **higher medical education**?

Pursuant to ICD-10, under the block of disorders and clinical conditions due to psychoactive substance use, severe health problems, consistent mental disorders, chronic course, as well as displays of long-lasting, reoccurring or ongoing adverse social behaviors mostly express the clinical conditions and disorders coded under fourth character codes "2", "3", "4", "5", "6", "7", "8" and "9" of this block of diagnoses.

Since the disorders and clinical conditions coded by fourth character codes "2", "3", "4", "5", "6", "7", "8" and "9" under this block are expressed by the sense of pathological craving to psychotropic substance (substances), withdrawal (abstinent) syndrome, increased tolerance to psychotropic substance (substances), psychopathological symptoms, adverse social behavior, it can be stated that for persons with the diagnoses under this block, the **observation "long-term" can be deemed well-grounded and proportionate**[20].

In the meantime, there are conditions described under the block of disorders and clinical conditions due to psychoactive substance use, given which the definition "long-term medical observation" in relation to persons involved and resulting limitation of their certain rights (for instance, exclusion of the opportunity to drive vehicles) cannot be deemed **grounded and proportionate.**

The aforementioned disorders include F10.0, F11.0, F12.0, F13.0, F14.0, F15.0, F18.0 and F19.0 ones, distinguished by the clinical descriptions, such as acute intoxication, its consequences and complications, that are mostly characterized by acute and short-term course (usually lasting from a few hours to several days), instead of long-lasting or chronic course of disorder, stable and residual disorders, ongoing or persistent adverse behaviors and displays of mental disorders.

[20] International Classification of Diseases, Tenth Revision

The clinical conditions coded under the above-mentioned disorders are transient, lacking the morbid compulsion to psychotropic substances.

Term “remission” defined in the decision **“On setting the procedure of medical observation and registration of drug users”** is another issue to be addressed in Chapter 3.2 below.

3.2. Remission in case of drug addiction. International trends

It is a well known fact that in case of diseases and disorders the most significant safeguard for effective treatment is the elimination (exclusion) of the cause. Moreover, in the vast majority of cases, consistent motivation of the patient towards cooperation with the doctor is ensured. Addiction to psychotropic substances is somewhat different. In this case the elimination (exclusion) of the cause leads to the aggravation of the patient's condition. Often irreversible changes in the human brain triggered by the use of psychotropic substances determine the individual's behavior both during the active use of psychotropic substances and in the post-withdrawal stage. This is why as a result of the so-called “detoxification” of a patient's organism and “withdrawal” of psychotropic toxins during the short-term detoxification treatment, as well as elimination of withdrawal syndrome, the patient’s sense of uncontrollable urge to psychotropic substances and related behaviors are not completely overcome, and as a general rule, there is a relapse of psychotropic substance use.

Back in the USSR and currently also in the majority of CIS states the so-called “metabolic approach” underlies the policy implemented in relation to drug users. If we try to analyze, we will be able to visualize that narcological medical assistance and care are limited to only detoxification treatment, usually lasting 10-24 days. Moreover, there are cases when only termination of withdrawal syndrome and detoxification (duration period is usually 3-7 days) are deemed by doctors as complete treatment and the patient is discharged in an improved state but without any measures to be taken in the post-treatment stage. In the meantime, back in the USSR and currently also in the CIS states “remission of persons with addiction to psychotropic substances” is depicted as total exclusion of psychotropic substance use, while the treatment effectiveness is assessed based on the duration of remission period following the treatment of persons with dependence on psychotropic substances.

However, different principles apply in European countries, Canada, Australia, and the USA. Instead of “remission”, term “results” is being applied in case addiction to psychotropic substances is observed. A number of factors and objectives are taken into account while evaluating the results in both European countries and the USA, guided

by evidence-based approaches regarding a specific disease counting the behavioral specifics, social consequences, and the patient's individual features. Particularly, according to the US experts, a long-lasting and consistent abstinence after the treatment of drug-addicted persons is quite rare. Taking into account all the negative legal, social, and health consequences of drug addiction, the efficiency of medical assistance and care is estimated based on the drug use issues. Formatted approaches imply evaluations in several focal directions.

1. Situation related to addiction inducing drug or psychotropic substance. The target result in this regard is complete remission. However, reduction of relapse (acute attacks) periods, decrease the frequency of substance use, reducing doses of psychotropic substances, as well as transition to "softer" psychotropic substances, exclusion or decrease in time lag of illicit drug use are deemed positive results ("achievements").
2. Employment indices. Measures directed at recruitment in jobs, continuing education, obtaining financial independence are also conceived as positive results.
3. Reducing or excluding frequency of domestic disputes, improving the level of social adaptation, acquiring new positive interests, and establishing positive relations with the surrounding.
4. General health condition. Actions directed at the treatment of other diseases, including complications of comorbid infectious diseases (especially HIV, hepatitis C, Tuberculosis) are deemed positive results.
5. Situation regarding the legal issues. Reduction or exclusion of criminal conduct directly related to the procurement of drugs, and other issues (injuries, car crashes, and other offences) due to drug use.
6. Mental state. Decrease or eliminate the frequency of displays of mental disorders, as well as improving the general mental health standing.

Thus, it can be emphasized that unlike the USSR and CIS countries (including our Republic), where **"How long has the patient been abstinent from drugs since the treatment?"** approach is widespread, the approach applied in European countries and the USA is **"Has the patient's conduct and lifestyle positively changed after the treatment?"**

Special tools have been tailored and are currently utilized in various countries for the effective assessment of addiction treatment. The most outstanding ones among

them are “Addiction Severity Index” [21] (“Addiction Severity Index” - ASI), developed in the USA and effective in a number of countries, Australia-based “Opiate Treatment Index” [22] (“Opiate Treatment Index” - OTI), and Britian-based “The Addiction Profile”[23] (“The Maudsley Addiction Profile” - MAP). All of the 3 tools serve as standard sets for the assessment of both addiction severity and addiction induced issues, such as general health condition, criminal behavior, risky conduct, nature of occupation, domestic and interpersonal relations as well as mental health. However, “Addiction Severity Index” is mostly applied for the evaluation of treatment efficiency, which is a regular interview with the patient based on standard questionnaire, comprised of over 200 questions. The duration of the interview is maximum 40-60 minutes.

The application of “Addiction Severity Index” for the effective assessment of narcological treatment is also recommended in the guidelines and manuals on narcological treatment, published by the WHO. [24]

As a result of assessment through “Addiction Severity Index”, it becomes possible to conduct effective dynamic observation of patiens, who have received medical assistance and care, moreover, upon necessity to respond and undertake required measures, such as referral to pharmacological treatment and psychosocial support activities, as well as provide objective assessment over the efficiency and quality of the type of applied narcological assistance.

Thus, the assessment through standard questionnaires allows carrying out in-depth professional analysis on the post-treatment state of the addicted person, and dynamics, as well as drawing objective inference by displaying individual approach to the patient.

A cornerstone principle of this approach is that addiction treatment requires a long-term (sometimes even taking decades) medical and additional support and care provided to addicted persons. Hence, the goal of agencies rendering medical assistance and care is not only the reduction and cessation of the use of illicit drugs or other psychotropic substances by the patient, but also implementation of a more systemic and effcetive policy, which implies complex rehabilitation measures directed at amelioration of patient’s health condition, quality of life, and psychosocial functioning.

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[21] http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/InstrumentPDFs/04_ASI.pdf

[22] http://www.who.int/substance_abuse/research_tools/opiatetreatmentindex/en/

[23] http://proveandimprove.org.uk/documents/Map.pdf

[24] Clinical protocols for the WHO European Region, HIV/AIDS treatment and care of injecting drug users.

3.3. Observations regarding driving of vehicles by persons with the diagnoses under "Mental and behavioural disorders due to psychotropic substance use" block

The block of disorders and clinical conditions of the ICD-10, "Mental and behavioural disorders due to psychoactive substance use" (F10-F19) includes a number of disorders due to psychoactive substance use, which are distinguished by the clinical course, duration, consistency and health-related consequences. Pursuant to ICD-10, under the block of disorders and clinical conditions due to psychoactive substance use severe health problems, consistent psychopathological symptoms, chronic course, as well as displays of long-lasting, reoccurring or ongoing adverse social behaviors mostly express the clinical conditions and disorders coded under fourth character codes "2", "3", "4", "5", "6", "7", "8" and "9" of this block of diagnoses. Since the disorders and clinical conditions coded by fourth character codes "2", "3", "4", "5", "6", "7", "8" and "9" under this block are expressed by the sense of morbid compulsion to psychotropic substance (substances), withdrawal (abstinent) syndrome, increased tolerance to psychoactive substance (substances), psychopathological symptoms, adverse social behavior. It can be stated that for persons with the diagnoses under this block, the observation "long-term" can be deemed well-grounded and proportionate. In the meantime, there are conditions described under the block of disorders and clinical conditions due to psychoactive substance use, given which the definition "long-term medical observation" in relation to persons involved and resulting limitation of their certain rights (for instance, exclusion of the opportunity to drive vehicles) cannot be deemed grounded and proportionate.

The below-mentioned clinical conditions related to the use of psychoactive substances do not serve sufficient grounds to deprive a person of the right to drive a vehicle.

When the fourth character of the code is "0" (F1X.0)

Disorders F10.0, F11.0, F12.0, F13.0, F14.0, F15.0, F18.0 and F19.0, given the clinical descriptions, such as acute intoxication, its consequences and complications, that are mostly characterized by acute and short-term course (usually lasting from a few hours to several days), instead of long-lasting or chronic course of the disorder, stable and residual disorders, displays of adverse behaviors or psychopathological symptoms.

The clinical conditions coded under these diagnoses are transient, lacking the morbid compulsion to psychoactive substances. Therefore, it can be stated that the

presence of any of F10.0, F11.0, F12.0, F13.0, F14.0, F15.0, F18,.0 and F19.0 disorders in a person's medical history cannot impede driving of vehicles, such as various other infectious and non-infectious diseases and clinical conditions accompanied by acute clinical course.

When the fourth character of the code is "1" (F1X.1)

Pursuant to ICD-10, F10.1, F11.1, F12.1, F13.1, F14.1, F15.1, F18.1 and F19.1 disorders are applied in cases when the use of psychoactive substance/substances by a person has directly inflicted damage to health. Moreover, the damage may be physical (as in case of Hepatitis C or HIV transmission from self-administration of injected psychoactive substances) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol). The aforementioned diagnoses imply psychoactive substance (substances) dependence syndrome with the sense of morbid compulsion to psychotropic substance and withdrawal syndrome. It is noteworthy that for F10.1, F11.1, F12.1, F13.1, F14.1, F15.1, F18.1, and F19.1 clinical conditions there can't be a single opinion regarding the secure driving of a vehicle. Let's consider two situations in examples:

1. If a person has contracted Hepatitis C or HIV through self-administration of injected narcotic drugs, but the syndrome of drug dependence is absent, then the reduction of the latter's ability to securely drive a vehicle can be excluded.
2. If a person has caused damage to his/her mental health due to the use of psychotropic substance and has acquired health problems featured by outstanding mood shifts, which can probably lead to adverse social consequences, then the reduction of the latter's ability to securely drive a vehicle is quite possible, although the person may not have dependence syndrome or related symptoms.

3.4. Recommendations

1. Review and revise the RA law on Narcotic Drugs and Psychotropic (psychoactive) Substances and the decree of the Government of Armenia "On setting the procedure of medical observation and registration of drug users" bringing them in line with current best practice, and international criteria of policy implemented in relation to drug users and drug addicted persons.
2. During the review and revision of legal acts clearly differentiate between the policy implemented in relation to persons with drug induced disorders (having addiction), and without addiction and those with drug use experience paying special attention to the expediency of severity of current restrictions against persons using narcotic drugs or other psychoactive substances, or persons with addiction to them and their punitive nature (including restriction of driving vehicles).
3. During the review and revision of legal acts pay special attention to and clearly define the application of internationally accepted approaches on diagnosis of drug addiction and registration based on it in order to carry out registration and medical observation of drug addicted persons.
4. Develop and introduce internationally accepted advanced principles and set of tools in Armenia for the assessment of effectiveness of narcological medical assistance and care provided for the treatment of psychoactive substance addiction, as well as the patient's post-treatment state and dynamics, by conforming them to local conditions and peculiarities.

SECTION 4. NARCOLOGICAL TREATMENT

The assessment of effectiveness of treatment methods (including cost effectiveness) provided to drug addicted persons in the RA, the comparison of efficiency of implemented treatment methods with standards recommended by international organizations, and best practice of other countries. The efficiency of policy implemented in relation to drug addicted persons in the follow-up stage of the treatment received at narcological clinics (including also actions targeted at maintenance of remission). The opportunities of inserting international best practice and its application the RA

4.1. Types of narcological medical assistance and care implemented in the Republic of Armenia, and regulating legal acts.

Pharmacological treatment of drug addictions, and related psychosocial measures overall focus on the following objectives:

- Reduction or cessation (exclusion) of drug use
- Reduction and prevention of damages due to drug use
- Improving drug addicted person's life quality

More often treatment of drug addictions requires provision of long-term medical assistance and care to drug addicts. In such cases the goal of clinics rendering medical assistance and care is not only the reduction or cessation of illicit drug use by the patients, but also carrying out measures targeted at the amelioration of the patient's health, quality of life and psychosocial functioning.

All the Armenia-based narcological clinics providing specialized medical assistance and care are guided by Order No. 532-A as of June 02, 2005 on "Standards on Treatment of Narcological Diseases in the RA territory" and Order No. 1440-A as of December 12, 2006 on "Clinical Guidelines on Opioid Substitution Treatment in Armenia", ratified by the RA Minister of Health.[25] [18,19]:

In general, three methods of pharmacological treatment of drug addictions are carried out in our country:

- Drug-free detoxification treatment
- Anesthesia-assisted ultra rapid detoxification provided for opioid dependent patients
- Opioid (with opiates) or Opioid agonist substitution treatment provided to opioid addicted persons

4.1.1. Drug-free detoxification treatment

[25] During the current analysis the 2015 clinical guidelines on Methadone substitution treatment for Opioid addiction and pharmacological treatment for Cocaine addiction, developed by the "National Institute of Healthcare after academic S. Avdalbekyan" CJSC under the RA Ministry of Healthcare, were not yet approved by the RA Minister of Health.

The detoxification method was the only drug addiction treatment available in the Republic before the introduction of substitution treatment.

During the detoxification the withdrawal induced symptoms that the patient is experiencing after ceasing drug use are alleviated and eliminated through drug treatment. The duration of withdrawal syndrome treatment usually lasts 3-10 days (contingent upon the type of drugs used before the treatment, severity of withdrawal state, and peculiarities of the patient's organism). Through drug treatment and psychotherapeutic measures the general psychosomatic condition of the patient is improved, the morbid craving for drugs is alleviated and eliminated during the following days or weeks. If possible, the accompanying clinical conditions and complications are also treated.

Detoxification treatment is provided both in inpatient and outpatient departments. The whole duration of the treatment usually differs from 10 to 24 days, after which the patient completes the treatment course significantly improved and is discharged from the clinic.[26]

Pursuant to Order No. 532-A on "Standards on Treatment of Narcological Diseases in the RA territory" issued by the RA Minister of Health on June 02, 2005, during the detoxification treatment the patient may be prescribed elimination of toxins, dehydration and antispasmodic treatment, analeptics, analgesics, tranquilizers, hypnotics, atypical antipsychotics, hepatoprotectors, suppressants of morbid adherence to opioids, vitamins, amino acids, nootropics, alpha-2 agonist blockades, Tramadol, opioid receptor antagonists (naltrexon and naloxon), inhibitors and proteases. In case of withdrawal syndrome experienced by a person receiving inpatient and outpatient treatment, Methadone and Buprenorphine are prescribed in order to relieve the symptoms.

According to the order on setting "Standards on Treatment of Narcological Diseases in the RA territory", anesthesia-assisted ultra rapid detoxification, and extracorporeal detoxification may also be prescribed for the treatment of opioid withdrawal syndrome.

During detoxification treatment the patient get consultations from narcologists, general practitioners, neuropathologists, general blood and urine tests, biochemical blood analysis, toxico-chemical analyses of blood and urine are administered, as well as ultrasound examinations for HIV and Hepatitis C.

[26] The number of bed days per person in narcological clinics within the state order amounts to a maximum of 24 days.

According to the order on setting "Standards on Treatment of Narcological Diseases in the RA territory", the necessary documents to be filled out upon the administration of narcological medical assistance and care have been approved.

4.1.2. Opioid Addiction Substitution Treatment in Armenia

In addition to other objectives, the "National Programme on the Response to HIV/AIDS epidemic in the Republic of Armenia for 2007-2011" approved by the RA Government Decision No. 398-N dated March 1, 2007 aimed to conduct HIV/AIDS prevention and damage reduction projects among injecting drug users, to support in the creation of a network of organizations implementing HIV/AIDS prevention projects, as well as introduce substitution treatment projects in the RA for drug addics. [20]

Among other issues, the "National Programme on Combating Drug Addiction and Trafficking of Narcotic drugs in the Republic of Armenia in 2009-2012", approved by the executive order NK-162-N of the President of the Republic of Armenia, dated September 25, 2009, put special emphasis on the efficient organiztion of treatment of drug addicts, modernization of narcological service, and introduction of social rehabilitation system. [21]

The "National Programme on the Response to HIV/AIDS epidemic in the Republic of Armenia for 2013-2016" approved by the RA Government Decision No. 232-N dated March 7, 2013 foresees developing and improving HIV/AIDS prevention and damage reduction projects among injecting drug users.[22]

"Methadone Substitution Treatment for Opioid addicted persons in the Republic of Armenia" has been implemented since October, 2009 by the "Narcological Republican Centre of the RA Ministry of Health" CJSC in cooperation with "Armenian Centre for Health Initiatives" NGO through the financial support of Open Society Foundations-Armenia, guided by N 532-A decree of the RA Minister of Health issued on June 2, 2005 on approving "the Standards on Treatment of Narcological Diseases in the Republic of Armenia" and N 1440-A decree "On approving Clinical Guideline of Opioid substitution treatment" dated December 12, 2006.

With an aim to insert Methadone substitution treatment in the detention facilities of the RA Ministry of Justice, a Memorandum[27] was signed between the departments of

[27] Methadone Substitution Treatment: Peculiarities in the RA MoJ detention facilities, H. Harutyunyan, 2014

penitentiary institutions of the RA Ministry of Justice and the RA Ministry of Health on May 26, 2010. [23]

Since August, 2010 "Methadone Substitution Treatment for Opioid addicted persons in the Republic of Armenia" project has been implemented by the Narcological Clinic of Psychiatric Medical Centre of the Ministry of Health of Republic of Armenia CJSC, since May, 2011 by the departments of penitentiary institutions of the RA Ministry of Justice, since July, 2012 by the "Lori Regional Neuro-psychiatric Dispensary" CJSC and since December, 2013 by Gyumri Mental Health Center CJSC within the scopes of grant project "Support to the National Program on combating HIV/AIDS Epidemic in the Republic of Armenia" funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria of the RA Ministry of Health. [1]

It is stated in the section of substitution treatment provision defined in the brochure on "Standards on Treatment of Narcological Diseases in the Republic of Armenia" that the duration of substitution treatment can constitute over 18 months. Thus, the maximum duration of methadone treatment for opioid addicted patients within the frames of Methadone substitution treatment projects is no longer than 18 months.

It should be noted from the beginning that pursuant to "Standards on Treatment of Narcological Diseases in the Republic of Armenia", the fact of defining 18-month period as a maximum term for substitution (conservative) treatment contradicts the principles recommended by WHO and United Nations Office on Drugs and Crime. Besides, the vast majority of opioid addicted persons provided methadone treatment within Methadone substitution treatment projects in the RA get treatment exceeding 18-month term, de jure violating the aforementioned decree of the Minister of Health on Standards of Narcological Treatment in the RA. [4,5]

Two types of Methadone substitution treatments are virtually applied worldwide: Methadone Detoxification Treatment and Methadone Conservative Treatment. During the Methadone Detoxification Treatment the drug doses are gradually reduced during the initially agreed (specified) period which is followed by discharge of patients in an improved state. Unlike detoxification treatment, the focal strategic goal of the conservative treatment does not simply imply the discharge of patients through gradual decrease of drug doses, but rather regulation of the lifestyle of opioid addicts, elimination of their criminality, exclusion of injecting drug use, and improvement of their quality of life.

If setting timelines in case of detoxification treatment matters greatly and is necessitated for the determination of various treatment schemes (schemes of gradual regulation and reduction of drug doses), then the conservative treatment does not stress the importance of timelines although not excluding the gradual reduction of drug doses

based on mutual agreement of the medical staff and the patients, along with their further discharge.

It is worth noting that at present the “Clinical Guideline of Opioid substitution treatment” does not comply with the current situation due to the following reasons:

1. Currently Methadone substitution treatment is provided not only in narcological clinics, but also in two regional medical facilities (Methadone substitution treatment are also planned in Syunik) and in department of detention facilities of the RA Ministry of Justice (including "Hospital of Convicts" DF). Whereas, the guideline points out about the head (by the way, no such position exists, since the clinics under “Psychiatric Medical Centre” CJSC have become closed joined stock companies under the RA Ministry of Health,) of only one specific narcological clinic (current “Narcological Republican Centre” CJSC).
2. Currently, 4 doctor-narcologists are enrolled in the Methadone substitution treatment project of “Narcological Republican Centre” CJSC. In this case it is unclear based on which grounds and principles the election of commission staff and distribution of their functions take place.
3. Although the Commission staff defined by the guideline is limited to 3 members, it is nonetheless worth noting that other unauthorized individuals also have taken part in the Commission sessions of Methadone substitution treatment projects. Particularly, a police official participated in the Commission sessions of narcological clinic’s Methadone substitution treatment project. Moreover, by his signature the aforementioned police representative approved of the protocols regarding the Commission’s decisions on patient admissions and exclusion (elimination, discharge). It should be stated that the Commission of detention department’s Methadone substitution treatment project is comprised of only doctors.
4. The Guideline was compiled in 2006, which depicts the Armenian situation on the use of opioids during 2004-2005. Whereas, the drug related situation in Armenia has significantly changed during the last decade.
5. All the steps and possibilities on prescription and tactics of treatment by doctor-narcologists are not thoroughly specified in the guideline.
6. The specifics (namely, the need to regulate Methadone dosages prescribed in addition to antiretroviral drugs provided to HIV-infected patients) of

regulating Methadone dosage in case of comorbid diseases are not thoroughly addressed.

7. Sometimes the patients enrolled in Methadone substitution treatment projects receive inpatient care for the first several days with an aim to undergo examinations, have drug doses regulated, and be subjected to medical observation, the necessity of which is not anyhow reflected in the guideline.

The presence of the police representative in the Methadone substitution treatment project and the latter's participation in MST implemented processes have no justification since the project is exclusively health oriented.

To get an insight into the project, the grounds for the police official's presence should be referred. Thus, back in 2007, via the RA Police Chief's response to the note of the Minister of Health regarding the appointment of a police representative in the MST project, a representative from Police was appointed in the aforementioned project without specifying his functions (which provides grounds to assume that the police official had to carry out functions within his position competence). The note however fails to specify that the police representative functions implied participation in the Commission's sessions, and moreover, putting signature in the protocols regarding the Commission's decisions. It should be added that an armed officer from the RA Police Protection Department carries out a 24/7 shift in the office of MST project implemented in "Narcological Republican Center" CJSC, who is in charge of security. Besides, a security alarm system communicated to protection department of the Police functions in the MST project office. It should be also emphasized the funding for the constant presence of Police Protection Department service official and the alarm system is also covered by the Global Fund. With this regard, the presence of another police official under the Commission for increased security measures of MST project seems totally unjustified. The police representative partaking in the Commission's sessions does not anyhow take part in the MST office security maintenance due to a simple reason: the latter is an officer of the Department on combating illicit drug trafficking of the GDCOC of the RA Police with his position relevant functions.

On top of all, the presence of the Police or another agency representative in methadone project with such a status contradicts legal regulations on narcological treatment. Hence, pursuant to the RA Criminal Code, divulging information on the patient's illness or the results of medical tests, by the medical personnel, without professional or official need, is punished in the order stipulated by the Criminal Code of the RA. It also contradicts a number of international legal acts. Thus, disclosing the data of a person undergoing inpatient treatment contradicts Article 17.1 of the

International Covenant on Civil and Political Rights, which was joined by the RoA on June 23, 1993. Actually, the current RA legislation clearly defines the cases when the disclosure of data regarding the patient under narcological registration or his/her illness to law enforcers is allowed. It is stipulated in the decree of the RA Government on Narcological registration dated 2007, according to which, the law enforcers can collect data on the person under narcological registration only based on a written inquiry. Whereas, the data of all the patients undergoing MST, also including those not enrolled in the MST project by the Commission's decision, are accessible to the Police representative taking part in the Methadone project Commission's session.

As a general rule, it is through the oral "demand" (or "suggestion") of the Police representative that MST project narcologist appoints a toxico-chemical lab analysis (an expertise to identify drug metabolites in the biological environment of a patient's organism) of the patient. The participation of the Police representative in the significantly important MST projects is inappropriate and unjustified, especially when we take into account that the project is provided with an armed official from Protection Department of the RA Police, carrying out 24/7 shift, and a security alarm system communicated to Protection Department of the Police. Moreover, the participation of the Police representative significantly reduces the project efficiency.

4.1.3. Anesthesia-assisted ultra rapid detoxification provided for opiate dependent patients 28

This treatment method has been introduced and applied in the RA since 2015.

The information posted in the official website of "Narcological Republican Center" CJSC regarding this treatment method is presented below:

Ultra rapid detoxification of opiate addicts is an up-to-date, efficient and safe method to withdraw opiates from the organism of opiate dependant persons.

The UROD method is a 6-8 hour general anesthesia procedure during which the patient is injected doses of opiate antagonists (blockers). Due to the quick nature of its administration and no awareness of physical discomfort, this method is greatly practiced worldwide.

It is a serious and costly intervention mandatorily carried out with the direct participation of an anaesthesiologist and rheumatologist.

Assets

- Short administration process: 6-8 hours
- No awareness of physical discomfort (the patient is asleep)
- Applicability irrespective of age and gender, narcotization period, and daily drug dose

Contraindications

- Pregnancy and lactation
- Acute psychotic illnesses
- Grave physical injuries

[28] http://narcocenter.am/sevices.html

4.2. Efficiency of narcological medical assistance and care types

In the vast majority of Soviet and post-Soviet countries the only goal while assessing the efficiency of narcological medical assistance and care methods is viewed as the maintenance of patient's remission in the post-treatment period, which implies lifestyle of complete abstinence from drugs. However, if remission is viewed as a target goal in case of ultra rapid detoxification and "classical" detoxification treatments for opioid dependence, then viewing it as the only goal for substitution treatment is quite impossible. The reason is that during the substitution medical care the patient receives opioids such as Methadone or Buprenophine on daily basis, which is the cornerstone for the efficiency of this treatment method. And although Methadone or Buprenophine are prescribed by a doctor-narcologist in medical doses, and even if the patient is abstinent from illicit opioid drugs, nonetheless, the patient is virtually exposed to "narcotic drug" substance. According to ICD-10, during the substitution treatment the patient's condition is diagnosed under "Mental and behavioural disorders due to use of opioids. Dependence syndrome; currently under clinical observation undergoing substitution treatment."(Code F11.22)

Instead of "remission" (absolute abstinence from drugs) concept applied in post-Soviet countries, term "results" are used in the USA, EU countries, Australia, Canada and in a number of other countries when the efficiency of treatment for psychoactive substance dependence is concerned, which is not limited to only one goal, but includes several other factors and objectives. In the post-treatment stage goals other than absolute abstinence from drugs are highlighted, which include reduction of drug use frequency or complete cessation, positive shifts in the patient's social status, domestic and interpersonal relations, financial standing, as well as improvement of mental state, presence of positive dynamics in the treatment of comorbid diseases.

As stated in Section 3 of the current analysis, in this case regularly filled out standard questionnaires are used for the assessment of treatment efficiency, which provide objective evaluation over the patient's health condition, lifestyle, and dynamics of behavior changes.

Along with the provision of a wide scope of opportunities for the objective evaluation of the treatment results, the focal goal of such an approach is constantly keeping patients, who have benefited from medical assistance, in the spotlight of healthcare institutions and organizations, change of medical tactics upon necessity, provision of additional psychosocial services, as well as effective oversight of patient's rehabilitation and resocialization process. Both in Armenia and in a number of CIS countries, after the completion of detoxification treatment and discharge of the patient from the clinic rendering medical assistance, the latter is denied any change of support except for the registration and medical observation carried out by the district narcologists. In the USA and EU countries follow-up actions, such as providing services of social workers, psychologists and psychiatrists, directed at the patient's rehabilitation and resocialization are undertaken after any type of detoxification treatment which significantly enhance the treatment efficiency.

It should be highlighted that the main purpose of "medical observation" defined by the decision of the Government of Armenia "On setting the procedure of medical observation and registration of drug users" is not the actual effective oversight of the health state of the patient, who has received medical assistance, but rather setting an "easier" mechanism for the elimination of the patient from registration several years later.

Although as compared with the last decade there has been a sharp increase in the demand for narcological treatment of drug addicts, however, it is noteworthy that the efficiency of drug-free detoxification treatment provided to drug addicted persons remains rather low, while the growth of narcological treatment demand is contingent upon quite different reasons, among them the introduction of substitution treatment in the Republic, and decriminalization of penalties envisioned for drug use.

After detoxification treatment drug addicted persons mostly relapse into drug use that is why the overall trust of addicted persons in drug-free detoxification treatment is still quite low.

The low level of demand for drug-free detoxification treatment is explained by the lack of competent psychosocial support, and post-treatment rehabilitation

services necessary for the treatment of patients with drug dependence, as set forth in the WHO standards and principles.

The lack of competent psychosocial support and rehabilitation treatment in the services provided to drug addicted persons leads to the incomplete social reintegration of persons, who underwent detoxification treatment, and recurrence of drug use by them in the future.

On the other hand, the demand for drug-free detoxification treatment has dropped even more, which is connected with the introduction of substitution treatment - a more effective treatment method provided to opioid dependent patients.[1]

Unlike the narcological detoxification treatment types, the substitution treatment is a type of long-term (usually lasting more than 6 months) or unlimited narcological medical assistance and care, coupled with psychosocial support and daily use of opioid agonists (only Methadone in Armenia).

Methadone substitution treatment includes biomedical, psychological and social components. This method of medical assistance and care is actually a rehabilitation service with biomedical, psychological and social components provided to opioid dependent persons in outpatient conditions. Through the substitution treatment the overwhelming majority of patients quit illicit opioids or reduce time lag of drug use.

The results of Methadone substitution treatment are reinforced through additional psychosocial service measures. The substitution treatment is often coupled with other types of long-term medical assistance, such as antiretroviral treatment provided to HIV-infected persons.

The assessment of cost-effectiveness and comparison serves a significant component for the evaluation of effectiveness of various methods of medical assistance and care provided for the treatment of drug addiction. The average daily expense for Methadone Substitution Treatment per person is 300-400 AMD, and 6000 AMD for “classical” detoxification treatment. If we consider the effectiveness of these two types of narcological treatments in terms of patient’s

abstinence from illicit drug use and resulting amelioration of life quality, decrease of criminality, the increased likelihood of treatment of comorbid diseases, it becomes evident that the Methadone Substitution Treatment is less costly and more effective medical assistance as compared to drug-free detoxification treatment.

A number of international reputable organizations such as World Health Organization, Joint United Nations Programme on HIV/AIDS and United Nations Office on Drugs and Crime also voice about the efficiency of Methadone substitution treatment and its cost effectiveness. [29] [24]

Pursuant to Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, published by World Health Organization in 2009, namely, the daily cost for methadone substitution treatment estimated per patient is US$1 a day in Islamic Republic of Iran, and US$10 and US$15 in the USA and Poland, respectively. [5]

Addressing Ultra Rapid Detoxification for the treatment of opioid dependence implemented in Armenia since 2015, it should be highlighted that this method of treatment is not deemed by international reputable organizations as an evidence-based approach. Namely, World Health Organization has not published any guideline or manual regarding this method of treatment.

It is true that anesthesia-assisted ultra rapid detoxification treatment services are available in various countries, including some states in the USA, Russian Federation, some CIS countries, however, previously conducted small-scale scientific studies and research cast doubt over the effectiveness of this method and infer that, as compared to other methods of opioid dependence treatment, especially substitution treatment, such an unreasonably costly method of treatment is quite ineffective in terms of safety, patient's health state during the treatment and increased risks of overdosing in the post-treatment stage.[30][31]

[29] WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention, 2004

[30] http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002022.pub3/epdf

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Besides, USA-based professional organizations dealing with issues on treatment of addictions also express a negative opinion regarding the effectiveness and expediency of anesthesia-assisted ultra rapid detoxification treatment by stressing that this method is not justified by scientifically-based evidence.[32]

4.3. Recommendations

1. To eliminate the incompliance of legal acts enshrined in N 532-A decree of the RA Minister of Health issued on June 2, 2005 "on approving "the Standards on Treatment of Narcological Diseases in the Republic of Armenia" and N 1440-A decree of the RA Minister of Health dated December 12, 2006 "On approving Clinical Guideline of Opioid substitution treatment" with the principles of the WHO, to develop and apply new standards providing efficient treatment based on international best practice.
2. To introduce rehabilitation services for drug users in the RA in line with the principles recommended by international reputable organization by applying the best practice of other countries.
3. Undertake measures in the training of psychologists, social workers in order to provide long-term psychosocial support services to drug addicted persons.

[32] http://www.asam.org/docs/publicy-policy-statements/1rod-urod---rev-of-oadusa-4-051.pdf?sfvrsn=0

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23 Methadone Substitution Treatment: Peculiarities in the RA MoJ detention facilities, H. Harutyunyan, 2014

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About Helsinki Citizen's Assembly-Vanadzor

Helsinki Citizen's Assembly-Vanadzor NGO /hereinafter HCA Vanadzor/ is a nonpolitical, non-religious, non-profit NGO, which unites individuals who support the supreme principles of Democracy, Tolerance, Pluralism, and Human Rights, as values.

HCA Vanadzor was founded in 1998 as a branch of Helsinki Citizens' Assembly Armenian Committee. It was registered as an independent organization in 2001 and was re-registered in 2005 at the Ministry of Justice. The Headquarters of the organization is in Vanadzor – Lori Regional Center. The geographical scope of the organization's activity covers both the Lori Region and the entire territory of the Republic of Armenia.

The Vision of HCA Vanadzor is a society formed with the supreme values of Human Dignity, Democracy and Peace.

The Mission of HCA Vanadzor is the promotion and support of civil initiatives, the strengthening of human rights protection, and peacebuilding activities on national and regional levels.

HCA Vanadzor has adopted a complex approach of human rights protection directed at both prevention of breaches of human rights and their reinstatement.

The Organization renders free of charge legal assistance, conducts human rights monitoring, legislative initiative, lobbing and actions directed at public awareness.

One of the focal scopes of activates carried out by Helsinki Citizens' Assembly Vanadzor in the sphere of human rights is the protection of drug addicted persons' rights. For the purpose of protecting the rights of this target group, the Organization provides free of charge legal consultations, and upon necessity it also ensures court representation. HCAV conducts human rights monitoring in narcological clinics and detention facilities along with monitoring of mass media outlets. The Organization implements analysis of national programmes in terms of human rights protection, and comes up with legislative initiatives and recommendations directed at the amendment of the current practice.

HCA Vanadzor has conducted monitoring over the right to fair trial of drug addicted persons in the General Jurisdiction Courts of Lori, Tavoush, Shirank marzes and administrative districts of Yerevan. During May-October of 2011 the Organization conducted a study over the preliminary investigation and court trial stage of persons charged with illicit drug turnover. As a follow-up to the monitoring and analyses conducted by the Organization, reports have been compiled and are available at the Organization's official website.[33]

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