



**Treatment Policy for Substance Dependence
in West Africa**

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Treatment Policy for Substance Dependence in West Africa

1 Executive Summary

This paper discusses treatment of substance use disorders in the ECOWAS region, clearly identifying an absence of demand reduction policies in the sub-region and significant challenges regarding access to treatment. In West Africa in general, drug demand reduction, particularly treatment interventions, is afforded inadequate attention and funding, while responses continue to place more emphasis on arrests and imprisonment despite a growing acceptance in other regions that these actions do not deter or treat drug use and indeed can also serve as important impediments to the provision of health services to people who use drugs.

Across the region, the availability of drug-related health and treatment services is limited. Most services are provided in psychiatric hospitals and traditional and faith-based facilities which tend to be overcrowded and are often characterized by abuses of the rights of clients seeking treatment. Those facilities that are available tend to be poorly funded, and lack personnel with the requisite skills and experience in managing substance use disorders. This situation exists in part due to lack of treatment policies that regulate the delivery of services in these facilities. It is also due to the fact that people who use drugs are often heavily stigmatized, and are deemed as not meriting the expenditure of state resources. The paper provides an overview of these challenges. It also puts forward a range of examples of effective treatment services provided elsewhere which can be adopted in the development and implementation of treatment policy in the ECOWAS region. These services include general counselling, drop-in services, self-help groups, family support groups, community aftercare and support services, specialized outpatient services, and medication-assisted therapies such as methadone for opiate dependence, specialized in-patient services and therapeutic community (TC) services. Techniques used in some of these services include cognitive behavioural therapy (CBT) and multidimensional family therapy.

The role of drug substitution therapy involving methadone and buprenorphine maintenance for opiate dependence is described in some detail in the paper. Opiate substitution therapy (OST) is both a treatment with a long track record (some 65 years, including in countries in Africa) for stabilizing opiate-related cravings, and while it is a form of harm reduction in that it makes injection unnecessary and thus reduces HIV risk and other injection-related harms, it is first and foremost a form of addiction treatment that has been endorsed by the World Health Organization (WHO). Yet, as we note, OST interventions are rarely practiced in the region due to several factors, including the lack of availability of substitution drugs due to non-inclusion in essential drugs lists of ministries of health across the sub-region, and preference among some policy-makers for abstinence-based therapies – i.e. those therapies that do not use opiate derivatives or other medications associated with dependence. In addition, based on experiences in other regions, the acceptability of opiate substitution is associated with the prevalence of opioid use, which at the moment is estimated to be at a low level in West Africa. Hence exploring the benefits of this form of treatment in West Africa may well be warranted in order to address the negative posture of both professionals and policy makers, and also in light of the increase in heroin trafficking and use across the sub-region (UNODC, 2013).

In addition, with indications of growing opioid use in West Africa and in response to calls for comprehensive responses to the drug-related challenges, the paper also notes that there might soon be a place for harm reduction programmes in the region. Though harm reduction aimed at addressing problems related to HIV/AIDS, injection drug use and other high-risk behaviours is very well established in some parts of the world and the methods have been shown to be effective, the uptake

has been slow in African countries. The paper explains why this is the case, noting that while introducing harm reduction programmes into drug policy in West Africa will require significant shifts in how drug dependence is viewed and in attitudes towards dependent persons, initiating an informed discussion on the topic is merited.

The paper also discusses the effectiveness of other treatment programmes and presents the views of experts and users of treatment services (via survey responses and focus group discussions conducted for the purpose of this paper).² Regarding the development and implementation of treatment policy across the region, the paper suggests the use of existing guidelines developed by the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC), while also emphasizing that in using these, attention should be afforded to social, economic and cultural factors in the countries involved.

In conclusion, the paper proposes that states across the sub-region should develop integrated drug policies along the lines of what is suggested in Section 5 (*A Drug Treatment Policy Framework for West Africa*). As a necessary starting point, such a policy framework should be centred on the goal of establishing effective and humane drug-related health services. The latter can be achieved by:

- Ensuring the availability of reliable data on drug consumption and addiction prevalence, as well as mechanisms that can sustain regular data collection and monitoring of trends.
- Assessing the cost-benefit ratio of drug-related health programmes.
- Ensuring well-trained and incentivized human resources.
- Ensuring the availability of a treatment system with stand-alone and dedicated facilities and the establishment of out-patient services in primary health care and social service facilities.
- Removing drug dependence treatment from under the psychiatric umbrella in order to remove the stigma often associated with treatment in psychiatric hospitals.
- Providing for community-based treatment and prevention, and ensuring built-in measures to address human rights concerns, human resources development, and avenues for collaboration with sister countries within and beyond the sub-region.
- Ensuring that drug treatment services, and drug treatment and other health and social support are provided as an alternative to criminal sanction. This will involve close collaboration between the criminal justice system and the ministry of health and other relevant agencies.
- Finally, and as a means to support implementation of its policy, each country should establish a centre (or agency) responsible for drug demand reduction matters, while also decentralizing its efforts and ensuring an emphasis on drug use as a public health issue and integrating responses into national development plans. This can also help ensure that external technical and financial assistance is more balanced in its support of drug policy, rather than the current trend of front-loading support to bolstering law enforcement capacities.

2 Introduction

Addiction to psychoactive substances has become a problem all over the world (UNODC, 2013) and many countries are making efforts to address the problem. Members of the Economic Commission of West African States (ECOWAS) have their share of the problem but have limited resources and

² The survey was conducted with participants at a workshop on the ECOWAS Project for Establishing the West African Epidemiology Network on Drug Use (WENDU) held in Abuja, Nigeria, from 25-27 June 2013. We are grateful to Dr Sintiki Ugbe, Director of Gender, Youth, Sport, CSO, Employment, and Drug Control, for granting the necessary permission to conduct the survey and to those who provided the invaluable information presented in this report.

expertise to tackle them in effective ways. For a long time these countries have had problems in dealing with licit substances like alcohol and tobacco, and are now being confronted with the trafficking of illicit drugs like cannabis, cocaine, heroin, amphetamine-type stimulants and precursor chemicals. While the fifteen ECOWAS nations differ in many ways for historical and cultural reasons, they share common characteristics in the realm of drugs and especially drug control policy. Most of these countries have been designated transit countries in the global drug trade and increasingly, as has occurred elsewhere, some of the narcotic and psychotropic substances being trafficked through the sub-region are remaining in the countries and are being consumed. Yet, African countries generally lack proper systems for monitoring drug use and are therefore unable to collect and store data on the extent of use and related problems (INCB, 2009).

However, there is growing evidence in the sub-region that young people in particular are using different types of illicit psychoactive substances (UNODC, 2013), the effects of which are increasingly being felt. And while drug addiction may be emerging as a significant public health concern, the response has lagged behind as no reliable data for the numbers of users, let alone number of addicted people exists in most countries. By extension, few if any country in the region have developed a comprehensive, evidence-based and balanced drug policy, and few apply available measures to counter the health and social impact of drug use. Indeed, this paper is particularly timely because very little work has been done in this area and various surveys show that treatment policy is largely nonexistent in many countries in the ECOWAS region (WHO, 2011).

One area requiring urgent work, therefore, is the development of a framework for the management of drug problems as a public health issue that can be adopted by countries within the ECOWAS region. The objective of this paper is to provide a technical basis for the development and implementation of integrated drug policies drawing from evidence of effective practices and with due consideration for the peculiarities of the West African context. Following from the policy brief on “Prevention and treatment of drug dependence in West Africa” (Obot, 2013), the paper draws on existing literature and findings from surveys to highlight the dearth of treatment services and the challenges that need to be overcome in the implementation of effective and more humane responses to drug dependence in the region.

3 Drug Use in the West African Region

As noted above, the issue regarding the unreliability or unavailability of data on consumption and addiction prevalence is significant, making it difficult to engage in informed policy discussions and ensure that limited resources are more effectively allocated. In addition and because so few countries report data, information regarding the prevalence of consumption and addiction is often dominated by what happens in Nigeria (although the data available in Nigeria can also be questionable). Notwithstanding, according to estimates reported by governments to the United Nations Office on Drugs and Crime (UNODC), more than 200 million people in the adult population globally used an illicit substance in 2011, an annual prevalence of about 5 percent (UNODC, 2013). This reported number of illicit drug users in the world is at best a rough estimate, as indicated by the large confidence interval around the point estimate, where the larger the interval the less precise the estimated number of drug users or any other parameter. In other words, a large range implies a high level of uncertainty about a particular measure (e.g., number of users, number of drug-related deaths).

Most of the drug users referred to smoking cannabis and many used a growing list of drugs including cocaine and heroin, amphetamine type stimulants and new psychoactive substances. It is estimated that more than 15 million users develop drug-related problems that might require professional help, usually in the form of harmful use, injection drug use or addiction to the substance (UNODC, 2013).

While the estimated rate of drug use in the general population seems to have remained stable over the years, the total numbers of people who use drugs and those among them who develop drug-related disorders have increased as a result of overall population growth.

In West Africa, illicit drug use is characterized by an overwhelming use of cannabis when compared to other substances. Indeed West Africa seems to be one of the epicentres of cannabis use in the world and within the African region (Table 1 below shows comparative prevalence of illicit drug use in various regions of Africa and the world). Based on data presented in the 2013 World Drug Report (UNODC, 2013), the table shows that the estimated prevalence of cannabis use in the adult population is highest in West and Central Africa (12.4 percent), compared to the African average of 7.5 percent and 3.9 percent globally. While this is a noteworthy difference, the unreliability of the data and the different assessment methods used in different regions makes it difficult to come to concrete conclusions. In addition, it is also important to recognize the limitations of the aggregate data for the region as some countries do not have reliable data or do not submit reports to the UNODC as requested. In other cases, some countries will report use of cannabis in lieu of 'hard drugs' as cannabis use may be less stigmatized.³

According to some studies conducted in the region, one characteristic outcome of cannabis use in West Africa is the association with psychopathologies of psychotic nature in treatment samples (Oshodi et al., 2009; Rolfe et al., 1993). Indeed in the minds of many health professionals and the public (in radio and television discussions), strong links are often made between cannabis use and mental illness. Though this reported association goes back many years (e.g., Asuni, 1964; Lambo, 1965), it is still not clear whether the link is causal in nature and why such association seems more prevalent in West Africa than in the rest of the world (UNODC, 2013). At the same time, a growing body of literature, including government commissioned studies, have raised important questions regarding cannabis pathologies, and associated social and health harms, and have led to important shifts in how cannabis is classified.⁴ In West Africa, existing studies generally show that high proportions of young people who are admitted for mental disorders also report some degree of cannabis use, which may or may not have precipitated the condition. Hence, in a situation where prevalence data (which in itself is still unreliable) suggests widespread use of cannabis in the region yet where many users do not develop any known psychopathology, the reported link needs to be made with caution.

³ Country visits of the WACD April 2013.

⁴ See for example, the UK Home Office Advisory Council's Report on the Misuse of Drugs: The Classification of Cannabis under the Misuse of Drugs Act 1971 in which after reviewing the evidence, the advisory body recommended that cannabis be reclassified to a Class C (least harmful) drug since "its current classification (under Class B – intermediate category) is disproportionate in relation to both its inherent toxicity, and to that of other substances (such as amphetamines) that are currently within Class B. Another more recent report from the same body endorses the keeping of cannabis in class C, not being reclassified as class B. Zabranský, T. 2004. Czech drug laws as an arena of the drug policy battle. *Journal of Drug Issues* 34(3):661–686; and Csete, J, (2012), A Balancing Act: Policy Making on Illicit Drugs in the Czech Republic, OSF Drug Policy Programme.

Table 1 - Prevalence (%) of drug use in different regions of Africa (adults 15-64 years, 2011)

Region	Cannabis	Opioids (synthetic narcotics)	Opiate (naturally occurring narcotic)	Cocaine	ATS
East	4.1	0.17	0.2	-	-
North	4.4	0.25	0.3	0.02	0.6
South	5.0	0.41	0.3	0.8	0.7
West/ Central	12.4	0.44	0.4	0.7	-
Africa	7.5	0.33	0.3	0.4	0.9
Global	3.9	0.7	0.4	0.4	0.7

Source: World Drug Report 2013 (UNODC, 2013)

While cannabis is estimated to be the primary drug of use in the region, other drugs are being consumed largely as a result of the growing availability of the drugs spurred by increases in trafficking in the region and, in the case of methamphetamine, local production. Unlike cannabis, which has been available in the region since the 1940s, cocaine and heroin are relative newcomers, having arrived in some countries in the early 1980s. Their use is estimated to have remained close to the global prevalence but with increasing access to these drugs, a surge in their use might be expected in the general population and in high-risk groups.

One class of controlled substances that might best illustrate the role of availability leading to consumption is the amphetamine-type stimulants (ATS), especially methamphetamine. This controlled substance became a favourite of West African traffickers a few years ago and local production has been reported in two countries – Nigeria and Liberia - in the region (UNODC, 2012). Given this local availability and with no reliable data, it can only be speculated that over time, the use of this drug may increase to levels being reported in other parts of Africa, a level that is similar to the global average.

Often forgotten in discussions of drug use in Africa is the phenomenon of abuse of prescription medications (psychotropic substances), which has been around for a long time. For example, dependence on pentazocine, a narcotic analgesic used in the management of pain, has been reported in Nigeria (Makanjuola & Olatunji, 2009). A recent study (Maiga, Seyni, & Sidikou, 2013) has also expressed some concern about the abuse of tramadol (another pain killer) in Niger, and during a recent country visit to Mali by WACD Commissioners, it was referenced repeatedly as a cheap option for problematic drug users (WACD country visit, August 2013).

Based on current developments, it might be expected that drug use will increase in West Africa in the immediate future. This increase could be accompanied by higher prevalence of substance use

disorders, although the lack of sound data does not yet allow for a reliable assessment of whether the prevalence of problematic addiction will actually rise. At least on the basis of anecdotal evidence, it seems that West Africa is not just serving as a channel for the global trade in illicit drugs, but home to a growing number of users, a small percentage of whom are addicted to opioids, cocaine, cannabis and legal substances. As noted by Kleiman et al, in their description of the 80 percent rule, in most places about 80 percent of the demand for illicit drugs comes from a small percentage, maybe 20 percent, of drug users who are the most problematic consumers with very high demand. Hence government-supported treatment services should target the most problematic users for the greatest impact not only on individual clinical problems, but also on overall demand (Kleiman, Caulkins and Hawkins, 2011). Already the absence of little specialized, longer-term, affordable, scientifically sound care for drug dependence in the region poses a challenge for low levels of dependence. Therefore, in the interest of public health and social welfare in the sub-region, governments should seriously consider ways and means of providing effective treatment to affected persons. The remainder of this paper is hence devoted to addressing issues of relevance to treatment policy and practice.

4 Managing Substance Use Disorders (SUDs)

4.1 Treatment as a component of drug demand reduction

Drug dependence treatment is a component of demand reduction. The term “demand reduction” refers to all activities aimed at reducing demand for drugs and includes primary, secondary and tertiary prevention (INCB, 2009). The ultimate goal of demand and supply reduction is to reduce or minimize the use of, and addiction to, drugs (INCB, 2004). Most of the countries in the ECOWAS region pursue drug control that incorporates the practice of demand and supply reduction. However for a long time this practice has been skewed towards supply reduction as most Governments are interested in arrests as evidence of good performance. Where anything is done to reduce demand for drugs, the major focus has been on “enlightenment” or “awareness” campaigns, an approach with little evidence of effectiveness in curbing demand (Babor et al., 2010). Addiction to drugs and interventions to reduce its impact on the affected or the society- at- large have been largely neglected.

Drug addiction is a complex illness characterized by intense and, at times, uncontrollable drug craving, along with compulsive drug seeking and use that persist even in the face of devastating consequences. While drug addiction begins with the voluntary act of taking drugs under various circumstances, over time a person's ability to choose not to do so becomes compromised, at least for a small percentage of persons. If not managed properly addiction can adversely affect the user, his family and society as a whole. It is indeed a well-established finding that drug use in general and drug use disorders in particular are associated with high social and economic costs (Rehm et al., 2006; Rice et al., 1990). Managing drug use disorders involves several activities often beginning with a thorough and comprehensive assessment of the affected person by a trained professional.

4.2 Treatment Services

It is important for policy makers to understand that a variety of treatment services with varying records of effectiveness exists, and that residential treatment is not the only answer. Residential treatment may be required in some instances but there are other approaches that have been shown to be effective. Unfortunately most of these services are not readily available in West Africa to people who need them, but they can be developed and/or adapted to suit each country in accordance with a country's human resources and financial capacity. In many countries in the sub-region, traditional and faith-based ‘treatment’ facilities provide some services. These centres tend to cater to clients with mental health problems but are seldom regulated by governments, and limited oversight is provided as a means to check the abusive and inhumane practices that have often been associated with these

facilities. For example, in some of these settings treatment for drug use disorders may mean physical and mental suffering inflicted on the client, often due to simple negligence or as a method of 'treatment', for punishing or correcting what is deemed a moral failing (Human Rights Watch, 2012). Not only are some of the methods used inhuman, there is no evidence that these types of interventions are effective in treating people with drug use disorders or any other psychological condition.

The following are brief descriptions of the specific services and techniques that are available, at least in theory, for the management of people with drug use disorders.

Drop-in services: This kind of service is geared towards provision of information and advice on service availability, where to go and what to do to obtain help. Such facilities should be provided in places that are accessible, with telephone facilities manned by trained and well-informed personnel who are able to intervene in emergency situations.

Appointment-based general counselling service: For economic reasons, this facility can be shared with the drop-in facility and should have some trained personnel in counselling attached. This facility can also serve as a clearing house where clients can be allocated to the relevant service available and judged to be most suitable to the client. This implies that there should be an experienced person on site who can assess the clients.

Self-help groups: Self-help groups like Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) are usually made up of people recovering from dependence who seek the company and support of similar persons. Treatment facilities should encourage their clients to establish self-help groups and provide assistance in their growth. Professional treatment programmes that emphasize self-help approaches increase their patients' reliance on cost-free association with groups and thereby lower subsequent health care costs. Such programmes therefore represent for some people a cost-effective approach to promoting recovery from substance abuse and dependence (Humphreys et al., 1999).

Family support groups: These groups are usually made up of family members of clients who play advocacy roles, share their feelings, experiences, support and learn from each other. These groups need to be helped to come up with the best ways to cope and deal with the multiple problems caused by drug use of their family members. Family support groups can be encouraged to work as NGOs to become recognized as part of a referral system.

Community aftercare and support services: It is important to identify the best professionals that can be entrusted with this responsibility. Often the community mental health personnel, where they are available, are the right people to turn to, although general community health personnel can also be trained to perform these duties. For example, trained social workers are usually part of a community team. The impact of addiction is felt beyond the person suffering from it so recovery from the disorder is much assisted by the participation of family members and others in the community.

Specialized outpatient services: This type of service is geared towards people in need of drug treatment and rehabilitation. Out-patient programmes can be very useful to those who must continue to work or attend school and these programmes vary depending on the patient's needs and the services available at the facility. More organized types of outpatient treatment may involve both individual and family therapy. A simple form of outpatient treatment might merely mean visiting a therapist who specializes in drug recovery.

Unlike inpatient treatment, outpatient treatment does not often address medical conditions and other needs. With inpatient treatment, everything is provided at one location. Due to its flexible nature,

outpatient treatment for non-complicated cases is often a preferred option. For adults with children, who cannot afford to attend treatment for months at a time, outpatient treatment can be a very helpful means of recovery.

Specialized in-patient services: In this type of residential care a client is provided with 24-hour care at a live-in facility. Both psychiatric and physical health care are included in this form of treatment. In most cases, patients will stay at inpatient treatment facilities for a period at time, depending on the policy of the institution or response to treatment. Before being accepted to this type of high-maintenance treatment, various assessments must be taken. The assessment includes psychiatric history, motivation for treatment, co-morbidities, employment and other relevant information.

One important difference between inpatient and outpatient treatment is the amount of medical attention received by a patient. In inpatient treatment, there is constant medical supervision of each resident. Also, detoxification is provided in many inpatient drug treatment centres.

For ECOWAS countries, in order to increase access, general hospitals could be staffed with trained personnel to undertake at least detoxification before referring them for adjunct psychological and other medical treatments.

Therapeutic community (TC): This type of residential treatment programme can be very effective, especially for those with more severe and complex problems. Therapeutic Communities (TCs) are highly structured programmes in which patients remain at a residence, typically for 6 to 12 months. The clients live a communal life where every member has a role to play in maintaining a therapeutic process that can lead to recovery. TCs differ from other treatment approaches principally in their use of the community treatment staff and those in recovery as key agents of change to influence patient attitudes, perceptions, and behaviours associated with drug use. Patients in TCs may include those with relatively long histories of drug addiction, involvement in serious criminal activities, and seriously impaired social functioning. The focus of the TC is on the re-socialization of the patient to a drug-free, crime-free lifestyle. So far there has not been any study on TC in the ECOWAS region. However, some studies in some western countries going back nearly thirty years have demonstrated its effectiveness particularly because of the duration of treatment requirement in the programme (Holland, 1993; De Leon, 1984; Dekel et al., 2004). This form of approach has been criticized elsewhere, not least because of the costs involved. In addition, it is unclear whether the alleged effectiveness of the treatment is in reality due to the substantive components of the therapeutic approach.

4.3 Drug dependence treatment and the criminal justice system

Treatment as an alternative to imprisonment for drug abuse offenders has been proposed to divert them into drug treatment programmes instead of jail. The latter allows them to receive treatment for a range of problems, including dependence, which could bring about significant improvements in their physical health and prevent recidivism (UNODC, 2010; INCB, 2007). Often the population of drug offenders on remand in developing countries is quite high. This is related to cultural beliefs that view such offenders as “bad people” who need to be punished. Yet, the numbers of offenders on remand is often due to other factors: in many places, offenders simply cannot pay bail or the going rate for a bribe that would have them released immediately. In other cases, drug related legislation is so harsh that the usual right to have one’s case heard promptly in some kind of tribunal is simply not respected. In yet other cases, offenders may be undergoing withdrawal while on remand and can be exploited for extortion or coerced confessions. Hence, while social stigma and demonization play a part, provisions in anti-narcotics legislation and the un-checked behaviour of officials and institutions can often be more damaging. Further investigation into these issues is urgently required in West Africa as a means to underpin policies being developed. Moving from a sentence-oriented to a health-oriented approach will be consistent with the international drug control conventions and also in agreement

with a large body of scientific evidence (UNODC, 2009) which shows that a health-oriented approach to drug use is most effective in reducing illicit use and the social and individual harms associated with it.

In this regard, law enforcement officials, courts and prisons will need to closely collaborate with the health care system to allow drug-dependent individuals receive treatment within the criminal justice system (if already incarcerated) or be diverted into treatment within the health-care system instead of jail. Fortunately both the ECOWAS Regional Action Plan (2008-2012; extended to 2014) and the African Union Plan of Action (2013-2017) recognize the value of treatment for drug dependence within the criminal justice system, and the AU plan specifically urges member states to “[I]nstitutionalize diversion programmes for drug users in conflict with the law, especially alternatives to incarceration for minor offenses” (ECOWAS, 2008: AU, 2013).

4.4 The Goals of Substance Dependence Treatment

Treatment must address the individual's use of drugs and any associated co-morbidity. It must also respond to any psychological, social, vocational, and legal problems that he or she may have. The goal of treatment should be geared towards recovery through many supportive systems that should be put in place. In general terms, recovery is generally characterized by voluntarily sustained control over substance use, health and wellbeing, and participation in society (UK Drug Policy Commission, 2008). Schukit (1994) contends that for most patients, the primary goal of treatment is attainment and maintenance of abstinence (with the exception of patients maintained on substitute substances), but this may take numerous attempts and failures at "controlled" use before success is achieved. Until the patient accepts that abstinence is necessary, it is suggested that the treatment programme should try and minimize the effects of continuing problematic use through education, counselling, and self-help groups that stress reducing risky behaviour. The patient is also advised to build new relationships with drug-free friends, change recreational activities and lifestyle patterns, substitute substances used with less risky ones, and reduce the amount and frequency of consumption, with a goal of convincing the patient of his/her individual responsibility for becoming abstinent. In other countries and regions, where the abstinence-based approaches promoted in the UN drug Conventions have not generated much effect, harm reduction has been championed as an effective alternative. Harm reduction refers to “policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption” (IHRA, 2010, p. 1), and includes health-oriented interventions such as opioid substitution, syringe exchange, heroin prescriptions and safe drug consumption rooms. Harm reduction policies can also respond to blood-borne infections such as hepatitis and HIV -linked to the use of contaminated injection equipment, and have been shown in multiple research reviews to be effective in reducing the health harms associated with drug use (Inciardi and Harrison, 1999).

4.5 Treatment Modalities

The management of substance use disorders is a long-term process involving multiple interventions and attempts at abstinence, and which require a lot of patience. The strategies used incorporate psychological, physical and social interventions. As appropriate these strategies are used often in combination with any of the services discussed above. The most frequent methods used by addiction workers are listed below. Based on formal and informal discussions with specialists from across the sub-region at international meetings supported by UNODC, some of these methods are already being used in the ECOWAS sub-region. There is however, no evidence that the methods that have been tried in the sub-region have been evaluated for their effectiveness. Hence, significant work still remains to be done to determine what works or does not work with regard to drug dependence treatment in the region.

Detoxification: Medically assisted detoxification is the first stage of addiction treatment and by itself does little to change long-term drug abuse. It is advisable that medically assisted detoxification be conducted in a residential setting in order to safely manage the acute physical symptoms of withdrawal. It should be supported with contingency plans to encourage the client to enter into and remain in treatment. For some, if this process is handled well it can pave the way for effective long-term treatment. However, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following recovery and therefore detoxification using concomitant psychological interventions like motivational enhancement and incentive strategies, initiated at initial patient intake, can improve treatment engagement. According to psychiatrists in the ECOWAS region, particularly from the Anglophone countries, substitution drugs (i.e., prescribed psychoactive substances which are pharmacologically related to the one producing dependence under medical supervision) are not widely used. Rather, benzodiazepines in injectable forms combined with psychotropic drugs are used in the acute phase and then switched to psychological forms of treatment in a multidisciplinary team. There is need for systematic research on this issue but anecdotal evidence from experts in the region seems to suggest that the 'fear' of substitute addiction is at the root of non-use of substitution drugs in treatment.

Psychological treatment: Counselling—individual and/or group—and other behavioural therapies are the most commonly used forms of drug abuse treatment. Behavioural therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programmes during and following treatment can help maintain abstinence. There is good evidence that these approaches to treatment, especially cognitive behavioural therapy (CBT), are associated with reduced drug use, as well as a decrease in drug related problems, criminal activity and infections (Babor et al., 2010).

Cognitive behavioural therapy (CBT): In CBT the therapist seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs. The drug abuse treatment programmes that use cognitive-behavioural therapy are so structured that the changes brought about by the programme are easy to measure. More reviews on the effectiveness of this treatment have been done than those on other types of modality (Caroll, 1997).

Two techniques that are often used in cognitive behavioural therapy and other therapies are motivational interviewing (MI) and contingency management. The technique of motivational interviewing capitalizes on the readiness of individuals to change their behaviour following which they are then encouraged to enter treatment. The contingency management approach utilizes positive reinforcement (rewards) to encourage abstinence from drugs.

Multidimensional family therapy: This approach to treatment often involves adolescents with drug use problems and their families as well, and it addresses a range of influences on their use patterns, including emotional, cognitive and conduct disorders. The approach is designed to improve overall family functioning.

Opioid substitution treatment (OST): Opioid substitution therapy (treatment) is the administration of a substitute medically approved and long lasting psychoactive substance for illegal opioids and opiates. The substitute is usually pharmacologically similar to the drug of abuse. Substitution medications generally help patients disengage from drug seeking and related criminal behaviour and become more receptive to behavioural treatments, and those that are administered orally have the great advantage of enabling people to stop injecting. Unfortunately these drugs are by themselves

addictive and should be controlled so that they do not end up on the parallel market through diversion.

In the ECOWAS region the use of substitution drugs has not developed to the extent found in some East and Southern African countries. This is because the prevalence of use of opioids, in general, and injection drug use, in particular, remains relatively low. Since it is likely that the use of these drugs will increase in the future if preventive efforts are not enhanced, workers in the field should be familiar with these intervention strategies. Two of the drugs most often used in substitution therapy are methadone and buprenorphine. Unfortunately in Ghana, for example, these drugs are not among the essential drugs imported into the country and are not licensed for sale in spite of WHO's inclusion of these medicines on the Essential Drugs list. It is likely that the status may be the same for most ECOWAS countries. This situation calls for reorientation of policy makers through operational research to convince governments to introduce substitution drugs into the country with effective mechanisms in place to prevent such drugs from being diverted into the unregulated market.

Methadone maintenance: Methadone, a long-acting synthetic opioid, was originally developed for pain control. It is now mainly used for the treatment of opioid dependence. Methadone Maintenance Treatment involves providing adequate oral methadone doses to heroin-dependent patients once a day, with the aim of reducing cravings for heroin. One benefit of methadone programmes is reduction of injecting and the harms of injecting, such as HIV and hepatitis, because methadone is administered without injection. It also reduces criminal activity, and eventually improves the quality of life of opioid users. However, several factors, including methadone dosage, adverse drug reactions, and methadone-drug interactions, can affect treatment compliance. Receipt of low or inadequate doses of methadone has been associated with higher rates of withdrawal symptoms and dropout rates. In contrast, increased dosage may cause somnolence, itching, hypotension, or even respiratory depression. Moreover, methadone-associated adverse reactions, including constipation, nausea, erectile dysfunction, sleeping disorders, menstrual cycle irregularities, may lead to disturbance of patients' daily lives.

Buprenorphine maintenance: This substitution drug suppresses withdrawal symptoms and relieves craving for heroin and other opiates. Some addicted persons feel more 'clear-headed' with buprenorphine than with methadone; other people have difficulties using methadone and, therefore, prefer buprenorphine. Buprenorphine tends to be easier to come off ('detox') than methadone so some people on long term methadone treatment switch to buprenorphine to facilitate detoxification. Again buprenorphine is addictive and in countries where this drug is used there are problems with its presence on the unregulated market due to illegal diversion.⁵

Oral methadone liquid and sublingual buprenorphine tablets are the medications most widely used for opioid maintenance treatment. In the context of high-quality, supervised and well-organized treatment services, these medications can interrupt the cycle of intoxication and withdrawal, greatly reducing heroin and other illicit opioid use, crime and the risk of death through overdose (WHO/UNODC, 2008). Opioid substitution therapy (OST) in situations of widespread opiate addiction has become an essential part of the treatment response to this problem, as well as a central element of HIV prevention. As noted earlier, OST is a rare response in West Africa as only one country

⁵ Conversely, in the US and many parts of Europe, some problematic drug users switch to buprenorphine because they can get take-home doses instead of having to present themselves daily at the clinic. Take-home doses have been provided because the authorities think that buprenorphine is less prone to diversion, or that the buprenorphine that is available is mixed with naloxone and is thus truly less attractive on the black market.

(Senegal) is developing this form of therapy, but it is becoming an essential component of treatment intervention in coastal East African countries and also in South Africa (IHRA, 2012).

Opioid substitution therapy (OST) has produced good evidence for reduced heroin use, reduced use of other drugs, crime, HIV infection, and hepatitis and increased social and economic stability, enabling people to hold jobs and be productive (Babor et al., 2010) and should be a treatment of choice where addiction to opiates is a problem. The major limitation of the findings on methadone or buprenorphine maintenance is that studies included in the evaluations of effectiveness are primarily from western countries. For example, one of the most well-known assessments conducted on the subject did not include a study on West Africa, hence the difficulty inherent in generalizing these findings (Babor et al., 2010). At the same time, however, and as noted earlier, opiate substitution therapy does have a 65-year track record in a broad range of countries across the globe, including Tanzania and Mauritius, as well as South Africa where private clinics across the country have made it available. OST has also been officially endorsed by WHO. Hence exploring the benefits of this form of treatment in West Africa may well be warranted.

Naltrexone maintenance: A third drug used in substitution therapy is naltrexone which works by blocking the effects of heroin or other opioids at their receptor sites and should only be used in patients who have already been detoxified. Because of tolerance issues, naltrexone is not as widely used as the other medications.⁶ In some countries naltrexone is used in the treatment of alcohol dependence.

Rehabilitation of drug users: The main aim of rehabilitation is to help drug users adjust to society and to overcome the many social problems associated with the habit. It is very important to manage family life, impart social skills, satisfy educational needs, and help to solve employment and accommodation problems. Drug rehabilitation can sometimes be used as part of the criminal justice system for people convicted for minor drug offences. Rehabilitation programmes ensure continued involvement of the recovering addict with the treatment systems and should not be treated as an after-thought but viewed as an integral part of service delivery. It is an effective way to prevent relapse to drug use.

Prevention of relapse: In relapse prevention clients are helped to identify activities of their interest and helped to pursue those activities and praised for engaging in such activities. Activities, like sporting, tourism, voluntary work to help others and attending self-help groups. The client is restricted from access to drugs if abstinence is the goal, advised to avoid social pressures to use drugs, and encouraged to look for drug-free friends. The client should be taught how to manage stress and situations that might trigger drug use behaviours. The ultimate goal of treatment interventions is to obtain abstinence but clients should be helped to reach this goal gradually and deal with the problem of relapse.

Harm reduction: Treatment for drug problems is an effective way of reducing or minimizing the impact of the various health and social consequences associated with addiction. Recovery is the ideal if not always achievable outcome of drug dependence interventions. In some cases and especially for some drugs there are public health policy options designed to focus not on eliminating use of the drug but on reducing the harm caused by the drug. Harm reduction comprises a long list of strategies, including the substitution therapies discussed above, needle and syringe programmes, outreach services, and provision of safe consumption environments (HRI, 2012). Needle and syringe programmes (NSP) may

⁶ Naltrexone is well documented to be clinically less well tolerated in this use.

reduce drug-related infections, including HIV, and facilitate treatment engagement (Babor et al., 2010).

Though harm reduction aimed at addressing problems related to HIV/AIDS, injection drug use and other high- risk behaviours, is very well established in some parts of the world and the methods have been shown to be effective, the uptake has been slow in African countries. Indeed, as shown in Table 2 and in the results of a survey of experts (see Table 3), only one country in West Africa has some type of harm reduction programmes and six in Africa as a whole. This is probably due to two factors: first is the relatively low prevalence of IDU-associated HIV⁷ in West Africa (recent studies show very high prevalence of HIV among people who inject drugs in Eastern and Southern Africa); the second factor is attitudinal – the widespread belief that harm reduction strategies represent approval for drug use and that only complete abstinence is desirable.

Table 2 - African countries with harm reduction in national policy and practice

Country	Explicit reference to HR in national drug policy	Needle exchange programme	Opioid substitution programme*	Drug consumption rooms
Kenya	Yes	No	Yes	No
Mauritius	Yes	Yes	Yes	No
Senegal	No	No	Yes	No
South Africa	No	Yes	Yes	No
Tanzania	Yes	Yes	Yes	No
Zanzibar	Yes	No	No	No

Source: Harm Reduction International (2012). *The global state of harm reduction 2012*

*There are differences in the available substitution therapies; Tanzania has a government-run programme, while in Kenya and South Africa the service is from private providers.

With indications of growing opioid use in West Africa (UNODC, 2013) and calls for comprehensive responses to the drug problem in the region, there might soon be a place for harm reduction programmes in more countries than the lone case reported at present. This will require significant shifts in how drug dependence is viewed and in attitudes towards dependent persons.

5 The Views of Experts and Drug Users in Treatment

How do drug control experts in West Africa view the drug situation in the region? What are the experiences of persons addicted to psychoactive substances and currently receiving treatment? In order to assess the views of these key stakeholders, a brief survey of policy and treatment experts representing ten of the fifteen countries in the region was conducted, and focus group discussions were held with clients in two non-government-run treatment facilities in Ghana. What follows are brief summaries of the two information gathering exercises.

⁷ HIV is predominantly caused by sexual contact though drug use often exacerbates the problem.

5.1 Survey of practitioners and policy makers

In order to understand the local situation better a survey was conducted to obtain information on the availability of drug control policy and treatment in various countries in the region. Using a semi-structured questionnaire data was collected from senior health experts and policy makers representing ten countries on several issues including the following: most used substance; availability of drug demand reduction policy, treatment facilities and specialists; practice of harm reduction; and the main challenges faced in addressing drug issues. Each of the ten countries at the treatment data workshop organized by ECOWAS that were present at the time of the survey was given one questionnaire. Almost all countries were represented by two experts who worked together to provide the information requested in the questionnaire. This was a highly knowledgeable group of experts in the position to understand the need for the required information and competent to provide such information. Nine of the questionnaires were completed and submitted to the researcher on the spot; one was sent via email after the workshop because of the need to check for some information on return home.

As shown in the responses reported in Table 3, cannabis was (as expected) mentioned as the major drug used in all countries, and cocaine by six of the ten countries. National drug demand reduction policy does not exist or is not being implemented in most of the countries; and where policy exists, standards for prevention and treatment are not included and impact of policy is not measured. Also emerging from the survey is the dearth of treatment facilities, specialists and near absence of harm reduction strategies in the region. Two of the main challenges enumerated in the responses -- lack of data and the paucity of human resources -- further reinforce well known problems in drug demand reduction in most of Africa. These are two of the challenges that must be addressed in the development and successful implementation of drug demand reduction policy.

Table 3 - Availability of national drug policy and treatment facilities in the ECOWAS region: the views of treatment and policy experts

Aspects of policy	Burkina Faso	The Gambia	Ghana	Guinea Bissau	Guinea Conakry	Liberia	Mali	Niger	Nigeria	Senegal
Most used drug	Cannabis, Cocaine, heroin, ATS, sleeping pills	Cannabis	Cannabis, cocaine	Cocaine, cannabis	Cannabis, cocaine, alcohol	Cannabis, cocaine, heroin	Cannabis, cocaine	Cannabis, tramadol, benzodiazepine	Cannabis	Cannabis, alcohol, cocaine, barbiturates
When was drug policy revised?	-	No national drug policy	2012	1994	No information	In process of drafting national policy	Work in progress	1999, 2000 but not implemented	2008, being reviewed	1996
Policy includes standards on treatment and prevention?	-	Mostly enforcement	No	Yes, detox and rehabilitation	No information	Will include all standards	-	No	Yes	No
How impact measured	-	Arrests	Seizures, Treatment demand	-	-	-	-	Never measured	Reports	None
Facilities available? Where located?	Psychiatric hospital	Yes, at Ministry of Health	Yes, psychiatric and private hospitals	No	No specialized treatment	In progress	No, but one psychiatric hospital	No. Psychiatric and general hospitals	Yes, list	Yes
Specialists available?	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes

Harm reduction programmes available?	No	No	No	No	No	No	No	No	No	Methadone maintenance coming
NGOs active in treatment?	Yes, two	No	Yes, religious groups	No	Yes	Two faith based	No	Yes	Yes	Yes
Support from development partners?	Yes, UNODC, France	Yes, WHO	Yes	Yes	Only one	Yes, UNODC, Colombo Plan	No	No	Yes, EU	Yes
Main challenges	Lack of data, rehabilitation and treatment	-	Inadequate funding	-	Lack of training, support, finance	Lack of rehab centres, financial support	No treatment centre, few specialists	No centre, human resources, finance, reliable support	Insufficient trained personnel	Lack of good coordination system

5.2 Focus group discussions

Two focus group discussions were held with groups of substance users in inpatient rehabilitation homes: the House of St. Francis at Ashiaman in the Greater Accra Region and Chosen Generation of Jesus Christ in Accra.⁸ Both are faith-based centres. The former operates using the 12-steps model. About 80 percent of the clients of both centres had passed through government-provided inpatient treatment facilities (Accra Psychiatric and Pantang Hospitals). The two facilities were visited on separate days and the clients were seen alone on each occasion and a period of two hours was spent at each facility. Fourteen clients were available at the House of St Francis and 46 at the Chosen Generation and they all agreed to participate in the discussions. Statements were read out to the group one after the other for deliberation and salient points were voted upon and counted by the show of hands. The numbers were noted as shown in Appendix 1. Though these numbers are small and may not be regarded as representative of drug users in Ghana, the findings nevertheless provide some insight into the experiences of the group of users residing in these facilities. They did not consider psychiatric facilities as appropriate for the management of drug dependent persons who had no psychotic conditions because of the stigma associated with mental illness and such facilities.

In both groups cannabis was the most common drug used followed by cocaine (in powder form). Also in both facilities injection drug use had been practiced by a few clients in the past but all of them, including non-IDUs, said that they were afraid of injections and complications including infections. In both groups, respondents suggested that a period of a minimum of three to six months with a maximum of 12 months should be sufficient to remain in treatment. Both facilities allow clients to stay as long as possible with a minimum of three months. Recorded responses are reported in Appendices 1 and 2.

A similar effort by the African Union on the drug situation and available services in Member States provides support for the above findings. Data from eight (8) ECOWAS countries that responded to the survey show the following: (i) Cannabis was the leading drug used in ECOWAS countries; (ii) poly-drug use was prevalent; (iii) the legislative and policy response framework focused on law enforcement; (iv) various key government institutions in the law enforcement and health sectors are charged with prevention and treatment; (v) and psychiatric hospitals were the main provider of services.

As noted above, no country in the sub-region has a comprehensive drug policy that responds to the issues raised above or the issues highlighted in the World Health Organization (2010) survey of substance use resources. What exists in every country is a form of drug policy that caters to drug control from a law enforcement perspective. Because drug addiction has now become a recognized problem in West Africa, the region urgently needs relevant treatment policies as part of a broader, integrated and sustainable drug policy. The major components of such a response are presented below.

6 A Drug Treatment Policy Framework for West Africa

WHO and UNODC have already developed guidance and principles for drug use prevention and treatment. It is important to emphasize that if ECOWAS countries use these tools to inform their own drug treatment policy frameworks, attention should be afforded to the social, economic and cultural factors in the various countries. Obviously there are many challenges in West Africa – previous situations of political instability, poverty, underdeveloped social service systems, massive

⁸ Permission for the visits was sought from the proprietor and the Chief Executive officer of Chosen Generation and House of St. Francis respectively and the residents agreed for the discussions to be held.

unemployment, particularly among the youth, manpower shortages and lack of welfare services -- which might make the application of principles and standards difficult in the region. At the same time, positive economic growth and stability in many countries across the region are windows of opportunity that should be taken advantage of. Moreover, respect for human rights of those in need of or undergoing treatment should be the starting point for the development of any drug policy.

6.1 Establish a national centre (agency) responsible for the prevention and treatment of drug use

This is an important first step in developing and sustaining a system of treatment services. The proposed agency should be responsible for the following:

- i. Serving as a clearing house (registration and accreditation) for all providers of drug use treatment;
- ii. Overseeing the activities of those involved in drug treatment, both governmental and non-governmental organizations (NGOS);
- iii. Monitoring and evaluation of such facilities;
- iv. Training of personnel in drug treatment;
- v. Preparation of treatment protocols for various levels of drug treatment;
- vi. Ensuring availability of adequate and relevant drugs for problematic drug use;
- vii. Providing guidance for drug treatment in the country, e.g., advice for the most appropriate and cost effective medications for withdrawal and maintenance treatment;
- viii. Providing specialized interventions, e.g., harm reduction; therapeutic communities.
- ix. Ensuring the availability of a team that will systematically monitor potential human right abuses in treatment centres, and report to appropriate authorities.

6.2 Decentralize drug treatment facilities

Drug treatment services should be located outside psychiatric hospitals where appropriate, and clients who do require treatment in psychiatric hospitals because of psychiatric co-morbidity and related violent behaviours should be managed in separate wards. Treatment facilities should be affordable and geographically accessible. General hospitals and outpatient facilities can serve as a first point of entry to treatment, meaning that trained and qualified staff in drug dependence treatment should be posted there.

6.3 Provide community-based treatment and preventive facilities

Drug demand reduction policy should include the creation of a network of facilities encompassing government agencies, social services, NGOs and community workers with support systems in the community that will address treatment, rehabilitation and relapse prevention and aftercare activities. Facilities should be culturally sensitive and multidisciplinary, and treatment should be voluntary. Health promotion concerning drug treatment, rehabilitation and prevention should be coordinated with primary health care activities.

6.4 Respect the human rights of people requiring and undergoing treatment

The World Health Organization asserts that “[d]rug dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. This includes responding to the right to enjoy the highest attainable standard of health and well-being, and ensuring non-discrimination” (WHO/UNODC, 2008) and the right to services that are voluntary, scientifically sound and not abusive. In addition, efforts must be made to ensure that abusive forms of treatment

are not used as a form of punishment by those who believe that drug use is a form of moral failing. Freedom to worship and spiritual growth should be assured – as should the freedom from coerced worship -- and equal opportunities for choice and benefits from available programmes in the country should be addressed through training and provision of high-quality services.

6.5 Build capacity for the delivery of treatment

Qualified staff will need to be recruited and others trained to be deployed to cover the available facilities in the country. Clear job descriptions of staff members should be defined. Continuing education and on the job training are needed for the delivery of high quality services. Staff should be adequately motivated and they should be given the opportunity to share and learn from sister countries in the ECOWAS region. There should also be opportunities for progression in service comparable with workers in other departments.

Teams of multidisciplinary nature made up of doctors, psychiatrists, psychologists, social workers, counsellors and nurses should be constituted to respond to the varied nature of drug dependence, including social support and provision of basic services such as housing. Recovering drug users can be used to assist in rehabilitation programmes.

6.6 Seek avenues for collaboration

Collaboration with local and international organizations can help in the promotion of best practices, which can be shared with other countries in the ECOWAS region. Drug demand reduction policy should actively encourage collaboration among NGOs and different types of treatment centres in the country.

6.7 Drug treatment as an alternative to criminal sanctions

In recognition of the fact that addiction is a health problem, drug policy might consider the inclusion of the establishment of drug courts to handle drug cases using multidisciplinary teams of drug professionals where there is enough capacity. The purpose of the drug court is to offer drug treatment as an alternative to criminal sanctions. This can be in the form of:

- i. Voluntary treatment without the threat of the criminal sanctions where case seeking activities of outreach teams engage drug dependent persons with minor offences who are not yet in treatment with the purpose of getting them into treatment. This approach uses reward systems to motivate drug users and agreements are made with law enforcement agencies regarding follow up (through for example, reporting) (UNODC, 2009).
- ii. Alternatives to imprisonment for drug users and drug dependent persons: As the possession and use of drugs are equally punishable, most ECOWAS countries will imprison offenders with limited quantities of drugs for personal use. The criminal justice system should instead refer cases to recognized and accredited facilities for treatment with consent from the offenders. There should be close collaboration with accredited health delivery agencies; this will reduce costs involved in custodial sentences and offer some dignity to drug offenders.
- iii. Drug treatment in prison: recalcitrant offenders who are dependent on drugs can be treated in prison. This calls for the provision of drug treatment facilities in designated prisons where they can be treated in humane manner without the abuse of their human rights.

Notwithstanding, it is equally important to note that as shown in a growing body of literature on drug courts, different models of these kinds of drug courts exist, and many of them have raised important due process questions. For example, in some settings, detainees are compelled to plead guilty to whatever offence they have been charged with as a condition for entering treatment. If however, they

'fail' in the treatment offered, they automatically return to the criminal system, and end up potentially worse off than if they had gone through a normal trial from the outset. In addition, treatment offered via the channel of drug courts often excludes opiate maintenance as an option. Moreover, such a channel also displaces decision-making regarding treatment from health professionals to the criminal justice system, particularly prosecutors. Hence, effort should be made to deepen understanding of these challenges before making a decision to go down this route.

6.8 Conduct cost-benefit analysis of drug-related health programmes

A number of careful studies of costs and benefits of drug-related health programmes published in academic journals in recent years demonstrate that the benefits of investing in good-quality services can far exceed the costs. Reviewing the evidence on opiate substitution therapy, for example, WHO and UNODC concluded that in crime reduction alone, investments in OST yielded benefits worth four to seven times the cost of the programmes, and counting reductions in health service costs from averting HIV and other harms, and benefits were about 12 times the costs.⁹ Since that review, studies of other kinds of treatment of drug dependence have had similar results, especially showing that averting crime and helping people to be economically productive can yield benefits well in excess of costs.¹⁰ Programmes that furnish clean injection equipment also have positive benefit-cost ratios where they are demonstrated to prevent HIV transmission. Though there are significant up-front costs to setting up good services where they do not exist, the argument that they are too costly to establish and run is not valid in light of a complete understanding of the benefits of these interventions.

7 Key Messages and Recommendations

Embedded in the principles listed above are some of the major challenges facing the provision of health care services to people with drug problems in the West African region. It will take a clear understanding of the seriousness of the problem and political will to confront the problem of drug dependence and other drug related disorders. There are signs that progress is being made on the awareness front; yet, if the situation is allowed to get worse in the coming years nobody will be left in doubt as to what to do to avert an epidemic of drug addiction because the knowledge base is available.

In addressing the challenges to overcome or areas that require greater attention we make the following recommendations:

National policy: Not every country in West Africa has a national drug policy covering both treatment and prevention and outlining clear and measurable goals, and strategies for achieving those goals. What does exist in every country is a set of regulations, which place emphasis on stifling supply through various law enforcement mechanisms. National policies are currently being discussed in some countries with the aid of bilateral partners and in response to the United Nations call for an "integrated approach" to drug-related challenges. However, if drug-related health services do not receive adequate funding, just having it on paper as part of an integrated policy will lead nowhere. Yet this is the kind of initial commitment required from nations in the region, a commitment that would benefit

9 World Health Organization, Joint UN Programme on HIV/AIDS (UNAIDS) and UN Office on Drugs and Crime. "Position Paper: Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV Prevention." Geneva: United Nations, 2004.

10 See review in J Csete, 'Costs and benefits of drug-related health services' made available to the Commission and forthcoming in D Quan and J Collins, eds. Economic impact of the war on drugs, a forthcoming publication of the London School of Economics.

from the guidance provided above. National drug policy frameworks should be centered on the following:

Data: The lack of data is a perennial problem but one that can be ameliorated with little effort. The recently launched West African epidemiology network on drug use (WENDU) is a good first step in the region. Countries should be encouraged to participate in WENDU and external partners should be encouraged to support it. Modelled after existing networks across the world, WENDU is a sentinel surveillance project initiated and managed by ECOWAS and which focuses on treatment demand data with the overall aim of providing regular information on drug use and dependence for use by policy makers and practitioners. The success of the project will depend to a large extent on the number of countries that join the network and are willing and able to share data on a regular basis. This project is expected to provide useful data on demand for treatment but it has several limitations as a means of gauging the nature and extent of drug use in the population. For example, because of the stigma associated with drug dependence some people refuse to seek help even where such help is available. This is a natural response to negative public perceptions and stigmatization of people with drug problems, which may also account for the inhuman and cruel treatment sometimes meted to them in many traditional or faith-based facilities.

Drug-related health programmes yield great benefits: As noted above, many drug related health programmes have proven that the benefits of investing in good-quality services can far exceed the costs. And while there are significant up-front costs to setting up good services where they do not exist, the argument that they are too costly to establish and run is not valid in light of a complete understanding of the benefits of these interventions. Efforts should therefore be made to conduct careful studies of the costs and benefits associated with drug-related health programmes.

Human resources: All available surveys of resources needed to sustain a system of services for addiction (e.g., WHO, 2011) paint a picture of substantial deficits in West African countries. Addiction professionals are a rare commodity where any can be found at all and primary health care workers who obviously come in regular contact with people suffering from drug use disorders are not trained to recognize or manage these problems. The future of a systematic and consistent response to these disorders probably belongs to this latter group of health care personnel through their role in early identification and brief intervention and as the first line of defence against addiction. Providing training on addiction counselling and basic care for this cadre of health care workers and to students and volunteers with interest in addiction services might serve as a cost-effective way to address the current human resources gap.

Availability of services: As much as trained and committed professionals for addiction services are lacking in West Africa, so too are facilities for residential or non-residential treatment. As reported earlier, much of what passes for treatment in the region takes place in unregulated private, often faith-based, facilities or psychiatric hospitals. Only a few of these hospitals have units for addiction treatment, but what is needed is a treatment system with stand-alone and dedicated facilities staffed with professionals, volunteers, and recovering persons. But that alone cannot take care of the problem; rather what is also required is the establishment of out-patient services in primary health care and social service facilities (e.g., screening and brief intervention). Addiction is a psychological disorder that is sometimes co-morbid with and sometimes accompanied by psychiatric conditions. However, depending solely on mental health facilities should not be the predominant option; nor should depending on NGOs and traditional or faith-based centres. Availability of and access to treatment will increase if general hospital personnel are trained and empowered to undertake at least detoxification before referral to appropriate specialized services.

External assistance: The US, the European Union, and other bilateral donors give significant assistance to West African countries for drug control. Health and social services for people who use drugs rarely figure importantly in these programmes. Technical as well as financial assistance in establishing scientifically sound and humane health services in this area, especially from countries with good services within their own borders, can be important in helping to steer new services in a good direction, as in the case of the US-funded methadone programme in Tanzania.

7.1 Conclusions

Addiction to psychoactive substances is probably a growing problem in the West African region due to a number of factors, chief among them being the increasing availability of these substances from local production and trafficking through the region. While the situation demands regular systematic assessments to monitor changing patterns of drug use and the prevalence of addiction, it is clear from available research and anecdotal evidence that addiction is already a real problem, and whether it increases or not, addicted persons very often have nowhere to go for help.

For any country, the first step in addressing this situation is the development of a national drug policy, one that incorporates all aspects of drug demand reduction and is anchored on human rights and public health principles. What is presented above can help in the work needed to develop drug policy but without the political will and a clear appreciation of the problem as a domestic public health and social welfare challenge then such policy will not exist or not be implemented. Implementing the ECOWAS Regional Action Plan to Address the Growing Problem of Illicit Drug Trafficking, Organized Crimes and Drug Abuse in West Africa (2008-2011, extended to 2014) is a good place to start but it will require political commitment and a clear sense of purpose to launch and sustain the activities listed under thematic area four on “Facing and dealing with the emerging threat of increased drug abuse and associated health and security problems” (ECOWAS, 2008). This will involve much more funding for treatment from national, bilateral and multi-lateral sources, training of appropriate manpower for treatment and rehabilitation, and support to civil society organizations for provision of services and policy advocacy.

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9 Annex 1

REPORT ON FOCUS GROUP DISCUSSIONS HELD ON THE 13 MAY 2013

VENUE: HOUSE OF ST FRANCIS ASHIAMAN

NO OF PARTICIPANTS: 14; TIME 1500- 1700HRS

Issue 1. Where they would like to receive treatment if they had the opportunity to decide

In answering the question on preference for type of treatment facility positive and negative comments were made about psychiatric hospitals, general hospitals, facility provided by NGOs, and dedicated facility by government.

a) Psychiatric hospital

100% of the participants in the focus group discussion did not like to be taken to the psychiatric hospital because of stigma. They could be mistaken as being mad; they would have low self-esteem when discharged which could precipitate drug use; and people could use it against them in future.

b) Dedicated Government institution

- May be political and will function well under one government and abandoned by another. Blames may be apportioned to government.
- Fears that they would not be managed well because staff will not be adequately motivated.
- Will be ideal if more trained staff and relevant medication would be provided as the cost for treatment may be cheaper because of Government subsidy.
- Some advocate for free treatment.
- The facility should be autonomous and operate with a multi-disciplinary team.

c) NGO facility

- Tend to be expensive but staff are usually dedicated.
- They use recovered addicts which is very important as they understand the process of addiction better and are able to share experiences in group meetings.
- Government should encourage more NGO facilities which should work alongside Government facilities.

Issue 2. What types of drugs they have you used before

Drug use	Number of users	Percentage
Cannabis	13	93
Cocaine	8	57
Pethidine	5	35
ATS	1	7
Morphine	1	7

Diazepam	4	28
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Issue 3. Why they chose to use drugs

Through friends and peer group; for fun; for socialization during schooldays which became a habit; curiosity and peer influences; they were shy and had low self-esteem and drugs made them feel bold; depression and inability to withstand stress.

Issue 4. Why some people are not using drugs

- Because of their belief systems and religion
- Not exposed to it and are aware that it is not good for them
- The way they were brought up
- They had good role models- their parents did not use drugs
- They were protected by their families
- Afraid of the consequences of drug use - disgrace to family and themselves, their future etc.
- Have good support from their families to be able to withstand peer influences.
- Afraid that they would go mad
- Protected genetically
- Insulated from environmental influences
- A combination of family influences and religion

Issue 5. How to protect the youth from using drugs

- Families should have time for their children
- Catch them young – send messages to schools –include drug awareness programmes in school education plans
- Use recovered addicts to tell their stories in the community - churches and schools
- Share experiences and use peer educators
- Counsel the youth
- Manage emotions of the youth
- Build support systems in schools and in the community
- Education service to have curriculum on substance abuse at junior school level
- Create awareness in the community

Issue 6. Length of time sufficient to stay in treatment

- It varies and would depend on the individual
- Minimum three months but 6 months to 12 months is realistic
- The longer in treatment, the better. However that would block others from receiving help if people stay indefinitely . 6-12months will do
- The length of stay should be dependent on the person ,his condition, past experience and the policy of the treatment center
- It depends on the therapist and the client .No time limit should be given.

Issue 7. Harms from drugs

- Limited social life
- Cannot function well in society. Lost self-esteem
- Lost opportunities

- Subjected to police enquiries
- Loss of respect amongst family members and the society
- Lost jobs ,disrupted marital life
- Feeling inadequate
- Infected with Hepatitis B and C
- Had problems with the Law and his education suffered. He later got into a state of helplessness and worthlessness
- One tried committing suicide but he did not succeed.

Issue 8. Experience with injection drug use

- 2 people out of 14 have injected heroin before.
- One had experimented and had problems locating the vein. He later became afraid that he would die and gave up.
- The second tried a few occasions and stopped because he was afraid that he would inject an adulterated drug and die.

10 Annex 2

FOCUS GROUP DISCUSSION AT ACHIMOTA

CHOSEN GENERATION: A SUBSTANCE ABUSE REHABILITATION CENTRE DATE: 28TH MAY 2013 NO OF PARTICIPANTS 46

This centre is a faith based facility that caters for about 100 Residents. The inmates include drugs users from Liberia, Nigeria and Togo. Permission was granted by the owner who had invited Dr Asare to speak to the group. The group was made up of multiple drug users who have been to various hospitals and spiritual centers in the past. On the day of the discussion, 46 clients were present. The questions put to them were similar to the ones asked to the group at House of St Francis. A summary of the responses to the issues raised is reported below.

Issue 1 Where they would like to receive treatment for addiction if they had the choice

The majority (that is 35 of them) would like to be treated at NGO facility because they thought that their recovery was effected through spiritual means. They would prefer to be managed in a “Christ centered” facility by somebody who has the calling for the job. [It seems obvious they had been influenced by the environment in which they were at the time.]

None of them wanted to receive treatment in a psychiatric hospital because of stigma and also because they would receive Largactil (an antipsychotic medication) which they believed would make them inactive and appear like “mentally” ill persons. Only three (3) would want to be in a Government dedicated facility. They had the impression that things provided by government were poorly managed and they would rather encourage Government to support existing facilities particularly the NGOs. They also said that Government should provide jobs for people who are rehabilitated.

Issue 2 What types of drugs they used

Drug use	Number of clients reporting use	Percentage
Cannabis	30	65
Cocaine/crack	21	46
Heroin	18	39
Injection drug use	2 (both from Nigeria)	4

Only two of the clients (both from Nigeria) had injected drugs; one of them experimented with IDU a couple of times ; the other abandoned the habit after 4 years of injecting. The reasons given for why IDU is not popular among clients admitted at the Centre were that they were afraid of injections and also they did not want to carry many things around. Some mentioned infections and poisoning.

Issue 3 Why they chose to use drugs

20 of them said for curiosity; 18 of them said they wanted to get “high”; 10 said to work hard; and 6 said they used drugs as an aphrodisiac.

Issue 4 Why they thought some people do not use drugs

The following reasons were given for why it is that some people do not use drugs: These people are well informed about the dangers of using drugs; Fear of using drugs; Mind set, that is they are conditioned by their parents so that they do not disgrace the family; Christian upbringing; lack of experience; fear of the Police and the law. Finally somebody said that those who did not use drugs were focused and were determined to aspire and would not allow themselves to be distracted.

Issue 5 Suggestions for preventing drug use among young people

The suggestions given by the clients included use of recovering drug users to educate people in schools, churches and community outreach programmes; 'catch them young'; include drug abuse prevention in educational curricula. Somebody said that we should create more awareness using the electronic and mass media.

Issue 7 What drugs have done to them

The responses given to the question on what drugs have done to them were as follows:

- Loss of jobs and relationships;
- One person said that drugs have "spoiled" him as he has lost a lot of opportunities;
- Many said that they had lost trust from family members because they had stolen money and some items from the house;
- They were regarded as liars;
- Drugs take away your freedom, bring disgrace to you and your family and you lose your dignity;
- 18 of them had dropped out of school, 15 had been confined in cells before, 15 were involved in fights, 40 of them have stolen items from home and outside the house; 8 were sacked from home and 8 ran away from home because of misdeeds.