Russia is in the grip of an epidemic of injected drug use, which authorities admit poses one of the country’s greatest health problems. But with the only government-sanctioned pharmaceutical treatment for opiate addiction, naltrexone, both controversial and prohibitively costly, doctors and groups working with drug users say that only a dramatic change in the Russian authorities’ attitude to the treatment of drug addiction will improve the situation.

“What we need to combat drug addiction is to have the entire armament to fight it, not just a piece of it,” Evgeny Krupitsky, of the Pavlov Medical University in St Petersburg, Russia, told The Lancet. “At the moment we only have full antagonist drugs available, in the form of naltrexone. We don’t have partial antagonists such as buprenorphine. And we don’t have full agonists, like methadone. What we need is everything already available elsewhere in the world to treat addiction. At the moment it’s like going to war with just machine guns and no tanks or missiles.”

According to WHO and UNAIDS, Russia has one of the world’s most serious injection drug-use epidemics, which in turn is fuelling an explosion in HIV/AIDS incidence. Research by HIV/AIDS monitors in Russia estimate that there are up to 2 million injecting drug users in Russia, 60–70% of whom have HIV-related illnesses. Up to two-thirds of new HIV cases in Russia are linked with injected drug use, and according to UNAIDS there are an estimated 1 million people with HIV in Russia. HIV prevalence in Russia has doubled since 2001.

The Russian authorities have come in for fierce international criticism over their policy towards the treatment of drug addiction, which relies almost exclusively on the promotion of abstinence. Opiate-substitution therapy, such as providing methadone, or buprenorphine, which is standard practice in much of the rest of the world, is banned by law, and promotion of its use is punishable by a jail sentence. Some Russian doctors who have advocated methadone use for drug users in harm-reduction programmes say they have subsequently faced harassment.

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The only pharmaceutical treatment legally available for addicts in Russia is naltrexone, an opiate antagonist that works by blocking opiate receptors in the brain. The drug is widely available in oral form in many countries. However, Russia is the only country in the world where naltrexone implants have been approved for use by authorities outside of study programmes. Doctors and researchers working with the implants say that their advantage over the oral form of the drug is that they ensure almost complete compliance on the part of the drug user.

Professor George Woody of the University of Pennsylvania, PA, USA, and chief investigator in a US National Institute on Drug Abuse-funded study of the implants being done in St Petersburg, told The Lancet: “All forms of naltrexone are good for drug addicts, but the obvious benefit of the implant is that the patient has no real choice whether they are going to take it or not. With oral forms they need to make a conscious decision every day whether to take it and if they do not that could have implications on their likelihood of a relapse. But with the implants they do not have to make that daily decision.”

Woody’s study, which also involves Krupitsky, is one of the largest ever studies of naltrexone implants, and is also the only double-blind double-dummy three-cell (active implant plus oral placebo versus placebo implant plus oral naltrexone versus oral placebo and placebo implant) study comparing an implant to both oral naltrexone and placebo implants. Although data are not yet mature, the researchers report that interim analysis shows that naltrexone implants are significantly more effective than oral naltrexone and double placebo. Other studies have also shown relative success with the implants. The results of an Australian study reported last year showed that naltrexone implants reduced cravings among heroin addicts, and resulted in 63% of addicts achieving abstinence for increased periods. By contrast, 62% of addicts who were given a daily naltrexone tablet returned to regular heroin use.

However, Woody and colleagues reported at least one case of a patient with an implant in their study who tried to overcome it by taking vast quantities of heroin to get a high until he finally
overdosed, barely surviving. Woody said that his study shows a higher proportion of patients with surgical infections with naltrexone implants compared with placebo implants, which researchers believe might be a result of addicts trying to take the implant out, possibly so they could get the full effect of an opiate hit again. Krupitsky has also indicated that long-acting naltrexone implants could increase suicide rates during treatment and fatal overdose rates in the post-treatment period.

Concerns over the safety of naltrexone have also been raised in other parts of the world. In 2008, doctors in Australia reported patients being admitted to hospital soon after being given naltrexone implants and suffering from opiate withdrawal, infection at the implant site requiring surgery, and, in one case, a psychiatric disorder. They said that the extreme reactions raised questions about whether naltrexone implants were a safe procedure. Some addicts have also complained that naltrexone does not help ease withdrawal effects or curb cravings for opiates, and that the desire to take drugs while on the implant can be so great that some have even tried highly risky do-it-yourself removals of the implant.

In Russia, people working with addicts in harm-reduction programmes are equally dubious about the worth of naltrexone. The implants cost about US$700 each, and last 3 months at a time. A 9-12-month course is recommended, and with the average wage in Russia about $560 a month, critics argue that it is an expensive and often ineffective treatment. Anya Sarang, president of the Andrey Rylkov Foundation for Health and Social Justice, Moscow, which works extensively with injecting drug users on harm-reduction programmes in Russia, told The Lancet: “not many people can afford this treatment. It doesn’t work very well and it does not stop the cravings for heroin or help the addict psychologically to stop. There are no good stories that I know of where people have got off heroin using naltrexone either in implant or oral form”. Other critics have also expressed concerns about the provision of the implants in Russia, claiming that little information is given to drug addicts about its safety. Doctors have also said they know of some clinics in Russia whose staff smuggle the implants into the country in suitcases from America where they cost a fifth of the price.

Dmitri (not his real name), a 28-year-old former heroin addict in Moscow, says that he tried, and failed, to come off heroin using naltrexone. He says that naltrexone alone is unlikely to be enough to help drug users conquer their addictions. He told The Lancet: “More than 2 years ago I went on oral naltrexone, and used it for 2 weeks. But then I wanted drugs again so I just stopped so I could get my fix. I relapsed and was on heroin for another year before I went to a rehab centre which worked with the 12-step programme. I have now been clean for 1 and a half years. In my opinion naltrexone can work for some people if it is given with proper psychological support. But it is important people get this as well as just the drug.” He says that opiate-substitution treatment as part of a harm-reduction programme, as offered in the west and other countries, could help many drug users.

UNAIDS officials have gone as far as to publicly say that the spread of HIV among injecting drug users could be largely stopped if opiate-substitution treatment combined with needle exchange programmes were offered. Others have pointed to the benefits of substitution treatment can bring to addicts receiving treatment for HIV. “In Russia, people who need, for instance, anti-retroviral treatment for HIV, need to go and stay in hospital for a lengthy period of time. But drug addicts will often disappear from hospital after a few days because they have withdrawal symptoms and leave to go and get their drugs. Having methadone available would stop them from leaving the hospital and abandoning their treatment”, said Sarang.

Critics of methadone treatment in Russia argue that it keeps patients in addiction, while others claim western countries want the treatment offered in Russia for commercial gain. They also warn that methadone would probably end up being sold on the black market, sparking another new drug problem. These arguments currently hold sway in Russia, with authorities seemingly unlikely to change their views in the near future. At the third annual Eastern Europe and Central Asia AIDS Conference last October, Russia’s chief medical official Gennady Onishchenko reiterated the government’s opposition to methadone, and claimed there was no evidence that its use in substitution treatment was effective. The comments sparked criticism by international health bodies.

Professor Gerry Stimson, executive director of the International Harm Reduction Association, told The Lancet: “the proportion of all AIDS cases linked to injecting drugs in Russia is 65%. The proportion of all injecting drug users who have HIV is 30 to 35%. In the UK, for instance, the prevalence among injectors is 1-5%. This difference is down to early and widespread roll out of methadone and needle exchange”. “It is hard to find a concrete reason why methadone and buprenorphine are not offered to drug addicts in Russia”, he added.

Ed Holt